MINIMUM STANDARDS FOR LOCAL DETENTION FACILITIES

TITLE 15 – CRIME PREVENTION AND CORRECTIONS
DIVISION 1, CHAPTER 1, SUBCHAPTER 4

2005 HEALTH GUIDELINES

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INTRODUCTION

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These guidelines address **Title 15, California Code of Regulations (CCR), the Minimum Standards for Local Detention Facilities**, related to medical and mental health, nutrition, facility sanitation and safety **(Articles– 11-14)** for adults. Guidelines specific to health needs of minors held in jails are located in **Articles 8-10**. There are additional guidelines that address adult **Title 15** program and procedure standards **(Articles 1-7)** and physical plant regulations found in **Title 24 CCR**.[1] These guidelines cross-reference regulations in other documents, all of which should be considered to put the medical/mental health, nutrition and sanitation issues in context with the overall operation of a local detention facility.

Guidelines are intended to explain the regulations, identify issues and propose options that should be considered when developing policies and procedures for implementation. There are many ways to comply with regulations; the guidelines offer ideas from professionals in jail management, health services, nutrition and sanitation as to what facility administrators might do, or at least consider, when implementing regulations. They are neither mandatory nor limiting, nor do they cover every possible contingency. They are intended to assist administrators and others in understanding the regulations and applying them to the needs of their particular detention system.

The regulations in this document closely relate to several regulations in **Article 5, Classification and Segregation**, which address: the immediate segregation of inmates with suspected communicable diseases pending a medical evaluation; identification of mentally disordered and developmentally disabled inmates; the use of safety and sobering (detoxification) cells; and the use of restraint devices. Those regulations are discussed in the **Guidelines for Title 15, Program and Procedures Standards**, but have critical components that require compatible health care and custody policies as well as a close working relationship between health and custody personnel. It is important that health care policies and procedures address these areas as well as those specifically described in **Articles 11-14**.

Title 15, Section 1007 enables pilot projects and **Section 1008** authorizes an alternate means of compliance. These options are available for health policies that meet or exceed the intent of a particular regulation in a unique or innovative manner. These avenues should be pursued with the Board of Corrections to implement a practice that deviates from a given regulation, but meets or exceeds the regulatory intent.

Each facility/system administrator should maintain a working relationship with their medical and mental health professionals, their local health department and interested practitioners. These resources offer assistance and support in providing jail health care that is consistent with the care provided in the community at large. Operating in compliance with the regulations and meeting the constitutional protections required in detention systems is necessary if the system is to avoid or prevail in costly litigation. Health care services are almost always a component of lawsuits

[1] There are comparable regulations and guidelines for local juvenile facilities.

addressing general conditions of confinement. The importance of medical and mental health services cannot be overemphasized.

One way to protect the system against problems is through the annual health inspection required by **Penal Code Section 6031.1** and **Health and Safety Code (HSC) Section 101045**. This inspection is the statutory responsibility of the local health officer and identifies areas of noncompliance with medical/mental health, nutrition and environmental health regulations. It provides critical information for system administrators. In order to avoid conflict of interest, the person(s) providing facility health and food services should not be the individual(s) who conduct the medical/mental health and nutritional portions of the annual health inspection. Service providers should conduct their own internal monitoring for quality improvement, but should not inspect themselves pursuant the above statutes, as this makes it difficult to avoid bias. While the health officer statutorily retains the responsibility for these inspections, options for avoiding conflict of interest include: having someone in the local health department who is not directly responsible for jail services do the inspection; sharing inspection teams with neighboring cities or counties; contracting with an outside consultant such as the Institute for Medical Quality (IMQ; formerly included in the California Medical Association) and others; or initiating the review with another resource in your community who has a thorough understanding of the regulations and jails.

Throughout the regulations there is the requirement for written policies and procedures. While it may be burdensome to write routine procedures and policies, doing so provides very real benefits. Written procedures are good management tools and training resources, document needs for budget requests, provide support in litigation, and give guidance for inspection teams as they review a facility. Written policy and procedures afford clarity and consistency of practice and will save time, money, confusion and perhaps lives in the long run. Well written procedures that are not adhered to will neither improve the health of the inmates in a facility nor protect the facility from damaging lawsuits. Practice must be consistent with policy and procedures.

Throughout the guidelines, there are numerous requirements to inform and communicate with inmates regarding a variety of aspects of medical and mental health treatment services. Non-English speaking inmates and others with language barriers, as well as persons with certain other disabilities, will require special provisions to ensure that they understand the information.

Title 15 medical and mental health regulations parallel those of the IMQ; however, they are not identical and adherence to **Title 15** regulations will not automatically make a facility eligible for IMQ accreditation. Among the differences between **Title 15** and the IMQ standards is that **Title 15** has no specific regulation for health care staff orientation or for a medical grievance process. **Title 15** incorporates these concepts in standards outside the medical and mental health sections; **Section 1069, Inmate Orientation**, and **Section 1073, Inmate Grievance Procedure**, both of which refer specifically to health care services and underscore the fact that inmates should be fully informed about health services and aware that they may air and resolve grievances relating to medical or mental health issues through the same process used for any other grievance.

Not everything required by statute is addressed in the regulations. For example, there is no **Title 15** regulation for methadone maintenance, but statute requires that those who are on a maintenance program when they come into custody should be permitted to continue at the

discretion of the director of the licensed community program (**HSC Sections 11222 and 11877**). The facility administrator should work with the local drug program administrator to develop methods to continue methadone maintenance or to initiate treatment for those inmates who need it.

Regulations related to food, bedding, and clothing are especially significant for facility managers, as they also have a basis in statute. **Penal Code Section 4015** requires boards of supervisors to provide food, bedding and clothing equal to or better than that required by these minimum standards. **Penal Code Section 4022** says that where a code uses the word "county" as in "county jail," it also refers to cities (as in "city jails") and "board of supervisors" may also mean "city council." Private facilities would be similarly bound as they are functioning as agents of the contracting entity.

While there is no specific regulation requiring preventive care, detention facilities are encouraged to promote a holistic approach to the health and wellness of inmates. For the well being of staff, as well as for the inmates, it is important to provide sanitary living conditions, proper food and exercise and, where possible, education about health maintenance.

Corrections Standards Authority[2] (CSA) staff is available to provide interpretation and assistance when questions arise about the regulations or guidelines. The CSA website (www.csa.ca.gov)[3] is a resource for information and makes provisions for contacting CSA staff electronically. The website contains both adult and juvenile regulations and their respective guidelines publications.

[2] Effective 7/1/05, the Board of Corrections was renamed the Corrections Standards Authority.
[3] If redirected to the master site for the Department of Corrections and Rehabilitation, click on the Corrections Standards Authority link.

ARTICLE 11. MEDICAL/ MENTAL HEALTH SERVICES

1200. Responsibility for Health Care Services.

(a) In Type I, II, III and IV facilities, the facility administrator shall have the responsibility to ensure provision of emergency and basic health care services to all inmates. Medical, dental, and mental health matters involving clinical judgments are the sole province of the responsible physician, dentist, and psychiatrist or psychologist respectively; however, security regulations applicable to facility personnel also apply to health personnel.

Each facility shall have at least one physician available to treat physical disorders. In Type IV facilities, compliance may be attained by providing access into the community; however, in such cases, there shall be a written plan for the treatment, transfer, or referral in the event of an emergency.

(b) In court holding and temporary holding facilities, the facility administrator shall have the responsibility to develop written policies and procedures which ensure provision of emergency health care services to all inmates.

Guideline: The regulation calls for the provision of emergency and basic health care services; it does not mandate how those services are provided. Facility administrators have considerable leeway in determining how health care services are handled in each facility. Some of the factors to consider include: physical space for examining rooms; sheltered housing for inmates needing medical and/or mental health services; closeness of local hospitals and/or emergency rooms; and staff time and transportation costs to take inmates out to medical services. Considerations such as these, coupled with the **Needs Assessment** [**Title 24, Section 13-102(c)2**] and the **Program Statement** [**Title 24, Section 13-102(c)3**] for new facilities, will help determine whether:

1. all health care will be provided outside the facility by transporting inmates to doctors' offices and/or hospitals;
2. only emergency health care will be provided by transporting inmates to doctors' offices and hospitals and basic health care will be provided in the facility;
3. all health care will be provided in the facility; or,
4. only first aid will be provided in the facility, with all other health care requiring transport to community medical services.

Personnel considerations will help determine if it works best to:

1. hire medical personnel to work in the jail as employees of the police, sheriff's, or corrections department;
2. contract with a local hospital, private doctor, private psychiatrist, medical group, , correctional health care company, or medical center;
3. develop a written agreement with the county health department to provide jail health care;
4. develop a regional agreement among several small counties to provide "roving doctors" and support personnel; or,

5. develop some other method of ensuring provision of health services in the most effective and cost efficient manner possible for a facility and/or system.

Additionally, new technology may be a consideration in providing health services. More facilities are using telemedicine to meet the needs of inmates. Experience has shown that specialty services, such as psychiatric visits, can be provided at reasonable cost, using today's computer video conferencing technology. If such technology is used, it is critical that issues of confidentiality, patient consent, and community resources for follow-up care be addressed.

Regardless of the service delivery method chosen, one individual should be designated as the health "authority" with responsibility for overseeing, planning, coordinating, developing and/or implementing health care delivery to the jail or jails (in conjunction with the facility administrator). The local health officer, a nurse, a facility physician, a private physician, or some other health professional can be named the health authority. A written agreement, which delineates areas of responsibility, is necessary between the facility's funding source and the health authority. If the health authority is not a physician, there must also be a responsible physician available to the facility to make those decisions that, by law, only a physician can make.

This section gives responsibility for ensuring provision of health care services to the facility administrator. The responsibility for all clinical judgments related to inmate treatment is the sole responsibility of the treating physician, dentist, psychiatrist or psychologist **(Section 1006, Definitions, Health Authority)**.

Section 1006, Definitions, defines the health authority as: "that individual or agency that is designated with responsibility for health care policy pursuant to a written agreement, contract or job description. The health authority may be a physician, an individual or a health agency. In those instances where medical and mental health services are provided by separate entities, decisions regarding mental health services shall be made in cooperation with the mental health director. When this authority is other than a physician, final clinical decisions rest with a single designated responsible physician." Thus, there is a distinction between the health authority and the responsible physician. The health authority is a medically trained individual who has responsibility for developing and/or managing health care services for a local detention facility or system. The responsible physician is a licensed clinician who provides health care services and is the final arbiter of clinical decisions. They may be the same person, but that is not required. In addition, the jail's facility/system administrator is charged with ensuring that health care services are provided and that the health authority and responsible physician operate within the policies, procedures and philosophy of the local detention facility or system **(Section 1200, Responsibility for Health Care Services)**.

The regulation envisions a cooperative, collaborative relationship between custody and health care personnel. This cooperation is essential because it takes the expertise of both health care providers and custody personnel to maintain order, health and safety in a detention facility. Security regulations apply to health care personnel as they do to all facility personnel. The facility administrator should ensure that health staff are oriented to and familiarized with security rules, regulations and procedures. They must understand the importance of, and their role in,

maintaining facility security. Likewise, custody staff should be informed about the duties and responsibilities of health services personnel.

The **Health Care Procedures Manual**, called for in **Section 1206**, describes how health care services are delivered, applicable security procedures, as well as the roles and responsibilities of custody and health staff. Additionally, regular meetings between custody and health personnel are recommended to help identify problems and devise mutually acceptable solutions. The facility administrator, health authority, responsible physician, mental health director, director of dental services and any other appropriate personnel should attend these meetings to discuss quality of care, security and operational issues and any other areas of mutual concern. Additionally, **Section 1202, Health Service Audits**, highlights the importance of administrative level communication to establish system-wide policies. With the exception of court and temporary holding facilities, **Section 1200** requires each facility to have at least one physician available to treat physical disorders. This does not mean the physician has to be on the premises at all times. "Available" means accessible, and may mean that the doctor is located elsewhere (such as at a local hospital or office). This physician would come to the jail on an established schedule and also on request. Note that each health authority will, in the Health Care Procedures Manual, define the parameters of health care to be comparable to what is available in the community. The jail administrator should maintain a copy of the **Health Care Procedures Manual (Section 1206)** to clarify questions about what services are provided and to promote consistency with custody policies and procedures.

In Type I, II and III facilities, which have full or part-time health care personnel, the staffing level should be adequate to assure timely access to sick call and timely provision of prescribed medication. The actual number of health care personnel necessary to meet these requirements varies widely among facilities. Mental health policy and procedures should be geared toward timely provision of service to inmates exhibiting behavior that warrants mental health attention and/or to inmates requesting such service. The scope of pharmaceutical services is addressed by assessing the quantity and type of medical/mental health treatment services being provided, number/types of drugs to be dispensed, etc. Dental services and personnel are largely determined by the policy delineating the level of dental service to be provided in the facility and can vary dramatically among facilities.

Answering the following key questions will help determine the appropriate staffing level for nurses, mental health workers, dentists and other health services staff:

1. *What is the Average Daily Population (ADP)?* The ADP may be higher than the rated capacity and health care coverage should address the true inmate population. This requires that the ADP (and the ADP projections, if planning for the future) be broken down into specific subcategories by service needs. For example: number of inmates requiring special mental health housing; number requiring other mental health services; number requiring dental care; number of emergencies per month; number of requests for minor medical and mental health attention; and number of inmates per month exhibiting signs of depression etc., which might require suicide prevention monitoring. In adult facilities that hold juveniles, health care staff has additional regulations, policies and procedures that must be followed to deliver health care.

2. *How many inmates are receiving medication?* This question will also help when determining the level of pharmaceutical staffing or extent of the pharmaceutical contract.

0. *What is the facility design?* Are services delivered to the housing units or do inmates report to a central clinic area?

0. *What is the level of security in the institution?* In a lower security area, inmates can present themselves to a central location and move through a line rapidly. In a high security area, a nurse may go to each cell, thus increasing staff time.

0. *What is the correctional staffing level?* Non-sworn health personnel may require custody escort. If the correctional staffing is limited, this can mean health providers are delayed in carrying out their duties, thus further increasing the number of health care providers necessary.

0. *What other programs are present in the facility?* How many inmates are non-sentenced and require frequent court appearances? If these inmates are taking medications, this may mean increased staffing is necessary during peak hours.

0. *How many tasks are performed during sick call and "pill" call?* More tasks mean more time in a unit, but perhaps fewer interruptions through the day.

The health authority and the facility administrator should explore all of these questions jointly. Then, based upon shared information, determine an appropriate staffing level.

Type IV facilities are included in **Section 1200** and these community release program facilities, like all others, are required to describe in writing how health care services are provided. Type IV jails most often utilize health care services in the community rather than having them duplicated in-house. The written plan for treatment, transfer or referral is essential to maximize the delivery of service and to enable staff to move quickly and appropriately in cases of medical emergencies.

When developing this treatment plan, the key is: if particular services are provided, the facility must comply with all relevant regulations; however, no facility is required to meet nonapplicable regulations. If a Type IV facility elects to provide health care in-house, it must meet all the medical/mental health regulations in **Title 15**. If it provides access to services in the community, it must have a clear written description of that approach, including policies and procedures to address portions of regulations that continue to apply. For example, most aspects of **Section 1216, Pharmaceutical Management**, are intended to apply where inmates are in actual physical custody or under the immediate supervision of custody staff. Inmates in Type IV facilities, who have community access for health care treatment, as well as employment, education and other programs, are not available for staff to observe ingestion of medications as required for inmates who are "in custody." That portion of the regulation does not apply; however, the facility must address how those medications are handled upon return to the facility. Do inmates keep their prescriptions on their person or locked in their personal storage, or are they given to staff? If

they are given to staff, policies and procedures should address accounting mechanisms and procedures to assure that the inmate receives the medication as prescribed.

Similarly, the facility administrator of a court holding and/or temporary holding facility is required to develop written policies and procedures which ensure provision of emergency health care services to all inmates. Regulations do not require a health authority or a responsible physician in these facilities.

1202. Health Service Audits.

The health authority shall develop and implement a written plan for annual statistical summaries of health care and pharmaceutical services that are provided. The responsible physician shall also establish a mechanism to assure that the quality and adequacy of these services are assessed annually. The plan shall include a means for the correction of identified deficiencies of the health care and pharmaceutical services delivered.

Based on information from these audits, the health authority shall provide the facility administrator with an annual written report on health care and pharmaceutical services delivered.

Guideline: This regulation is applicable to facilities with in-house health care services, however limited, and with assigned medical and mental health staff. Not relevant to applicability is whether the health care staff is funded through the detention budget, are city or county employees or are private providers. This regulation does not apply to court holding and temporary holding facilities or Type I jails that rely only upon an emergency room or contract physician outside of the facility to provide medical services. This limitation notwithstanding, it may still be useful for these facility administrators to prepare statistical summaries on outside medical care that has been provided to assure oversight of medical costs.

For facilities with in-house health care services, the written plan for health service audits must address three areas: a system for conducting internal quality assurance reviews that identify service inconsistencies and other problems; statistical summaries which outline the services delivered; and, a mechanism for correcting identified deficiencies. At least annually, the health authority is required to summarize the findings of these audits and plans for correction in a report to the facility/system administrator. This report should incorporate the findings of the pharmacist's report on the status of pharmacy services (**Section 1216, Pharmaceutical Management**), but is not a substitute for that report.

The audits and (at least) annual reports to the system administrator help both the administrator and the health authority assess what is and is not working and provide a starting place from which to jointly identify problems and propose solutions. Since health services are a substantial portion of a jail's budget, this process is an essential management tool.

Central to this standard is monitoring for internal quality control through internal audits. Even though this regulation requires annual assessments, quality review and control must occur on an ongoing basis. Except in unusual circumstances, this process of internal quality assurance can be accomplished only by on-site monitoring, which should be documented at least monthly as an internal quality assurance report. This documentation is a health care, not a correctional,

function and should be maintained within the medical and mental health services unit. While medical records are probably the main source, other possible means of generating audit information include:

- studying outbreaks of illness such as diarrhea, flu, etc. (i.e., morbidity review);
- studying deaths in custody (i.e., mortality review);
- individual case review;
- monitoring activities of clinical staff (e.g., review of use of restraints, seclusion, hazardous procedures, etc.);
- review of similar diagnoses (e.g., all diabetics);
- review drug use (psychotropics, antibiotics, narcotics, etc.);
- review of policies and practices;
- study of all suicides and attempts;
- liability claims review;
- data obtained from staff interview and observation of inmate medical and mental health services;
- consideration of implementation and status of standing orders (for custody personnel) or standardized procedures (for registered nurses); and,
- review of inmate complaints.

In addition to internal monitoring for quality assurance, statistical summaries of services delivered must be developed and maintained by health care staff. This information provides the facility/system administrator with a basis for accountability and future service planning. Elements of the statistical summaries include:

- number of sick call visits:
  - by nursing staff,
  - by physicians;
- number of health inventory evaluations (if seeking accreditation);
- number of food service worker screenings;
- number of laboratory tests performed;
- number of new prescriptions filled;
- total number of prescriptions;
- number of medication doses administered;
- types and numbers of communicable diseases seen and treated;
- if the facility has a health care housing unit, the average daily occupancy for medical/mental health services and average length of stay;
- number of emergency department visits;
- number of specialty clinic visits;
- number outside appointments for:
  - laboratories,
  - X-ray,
  - electrocardiograms,
  - electroencephalograms;
- profile of hospital admissions:
  - number of hospital admissions,
  - types of diagnosis,

- total patient days;
- dental services provided:
  - number seen on-site,
  - number referred; and,
- transport (custody staff should keep records of the number of inmates transported and the time involved to provide such care).

While somewhat different from internal audits and statistical summaries, the health authority may additionally determine that a more detailed quality improvement program is appropriate. Due to concerns regarding medical/mental health confidentiality and discoverability of such audit proceedings, the review is sometimes arranged through community hospitals through their quality assurance programs. This process affords a non-biased review, based on community standards of care. Procedures for these reviews should be guided by advice from county legal counsel to determine the applicability of confidentiality protections. However, experience has shown that many hospitals are unwilling to perform this service since the Ninth Circuit Court overruled California statute protecting "peer review" and medical staff activities.

In addition to the internal audits and statistical summaries performed regularly within the facility, there are also annual inspections by the local health officer for compliance with the medical, nutrition and sanitation regulations contained in **Articles 11-14 of the Minimum Standards for Local Detention Facilities**, per **Penal Code Section 6031.1** and **HSC Section 101045**. As noted in the introduction, to avoid conflict of interest with regard to these inspections, the person(s) who provide health care services in a facility should not conduct the medical/mental health portion of the annual health inspection. Service providers should regularly perform their own internal inspections to assure quality and consistency, but they should not be inspecting themselves to comply with this statutory requirement.

Audit services should enhance, but not replace, regular administrative meetings. Meetings between the facility/system administrator, the health authority and responsible physician should be held at least quarterly to assure that policy level issues are addressed.

The purpose of audits and reports is to ensure quality care and optimum service delivery. A plan and the timely correction of identified deficiencies are essential. Documented efforts to correct problems will be valuable if the jail is involved in litigation. The audit process can also facilitate future planning and affords both custody and health care staff a means to document services provided and identify areas that require additional attention.

1203. Health Care Staff Qualifications

State and/or local licensure and/or certification requirements and restrictions apply to health care personnel working in the facility the same as to those working in the community. Copies of licensing and/or certification credentials shall be on file in the facility or at a central location where they are available for review.

Guideline: The facility/system administrator, in conjunction with the health authority, must ensure that qualified staff working within the scope of their license or certification provides

health care services. The facility administrator and health authority must be certain that health care personnel working in the facility:

0. have valid California licenses and/or are certified to provide care;
0. are working within the scope of practice described by their particular license or certificate; and,
0. are keeping their licenses and/or certificates current.

While the task of verifying the validity of licenses and/or certificates may properly belong to the health authority, the facility/system administrator should participate in developing the written policies and procedures for verification. These policies and procedures should require: that the license be presented to the health authority for inspection; that it be reviewed, verified and recorded; that special note be made of the requirements for renewal; and that a schedule is set up for the appropriate periodic inspection. This information, along with a copy of the licensing or certification credentials, is to be kept on file in the facility or, in a multi-facility system, at a central location where they are available for review. Written verification procedures can include requests for copies of educational certificates and course content to verify scope of practice.

Health personnel required to have Califomia licenses through the Department of Consumer Affairs include, but are not limited to:

physicians	vocational nurses
pharmacists	physicians' assistants
dentists	medical assistants
dental hygienists	psychiatric technicians
registered nurses	clinical psychologists
nurse midwives	psychological assistants
clinical social workers	

Categories of “nurse practitioner” and “public health nurse” are not specifically licensed, but their members are registered nurses. Appendix 1 includes licensing agencies websites that can be used to verify licensure status, and address a variety questions regarding activities licensed and certified health personnel can perform.

If there is an xray unit in a local detention facility, the person(s) taking the xrays must be qualified and certified to do so. People who operate the equipment must wear film badges that are monitored and the xray equipment must be registered with the state. There must be a certified xray supervisor (MD) for the equipment and a radiologist should read all xrays. Moreover, the health authority should insure the equipment is inspected and registered as required by the Department of Health Services (DHS).[4]

Some allied health personnel categories are not licensed, such as paramedics, emergency medical technicians, etc. The health authority and facility administrator must take every precaution to guarantee that members of such categories do not practice medicine or perform duties for which

[4] Title 17, Public Health, Division 1, State Department of Health Services, Chapter 5, Sanitation (Environmental), and Subchapter 4. Radiation.

they are not legally qualified. The liability associated with unqualified and/or unlicensed personnel or allowing staff to work beyond the scope of their licenses greatly exceeds any cost savings that may be produced by lower salaries. Staff who work beyond the scope of their license could lose their license and be criminally prosecuted if an inmate is injured by their actions.

The Licensing Boards for health care professionals are under the jurisdiction of the State Department of Consumer Affairs. Regulations governing the practice of registered nurses, licensed vocational nurses, and physician assistants, etc., can be found on the Web at www.dca.ca.gov/. (Please see **Appendix 1** for a list of licensing boards, including their websites.)

1204. Health Care Staff Procedure.

Medical care performed by personnel other than a physician shall be performed pursuant to written protocol or order of the responsible physician.

Guideline: Whenever the responsible physician determines that a clinical function or service can be safely and legally delegated to non-physician health care staff, the activity must be performed by staff operating within their scope of practice pursuant to a written protocol or medical order. The responsible physician must develop protocols or standardized procedures for health care clinicians to provide specific treatment of identified minor, self-limiting conditions and for on-site treatment of emergency conditions.

Direct orders are those from a physician to qualified health care personnel, allied health personnel or medically trained corrections staff that instruct them to carry out a specific treatment, test or medical procedure on a given patient. Protocol or standardized procedure refers to the procedures to be followed in the performance of a clinical function.

A physician should delegate services only if the designated staff are properly:

- qualified for performing and legally permitted to perform such service;
- trained in the provision of such services; and,
- trained in the appropriate procedures for ensuring safety and confidentiality.

Whenever the physician determines that a clinical function can be safely delegated, that function will be performed pursuant to a protocol or standardized procedure that shall:

- be in writing, dated and signed by the physician in charge (The health care administrator and/or nursing administrator should also sign the protocol.);
- specify and outline the procedure to be performed;
- establish the required training for personnel initiating the protocol;
- establish the method for evaluating continued competence of persons authorized to perform clinical functions;
- state the limitations or conditions/settings in which protocols may be performed; and,
- be reviewed and updated at least annually.

The facility administrator and facility manager must work closely with the health authority and responsible physician to clarify any roles which custody/correctional staff may have in health care service delivery. Custody staff must be trained if they are used to perform a health related function. Therefore, it is especially important that the facility administrator work with the health authority and responsible physician to establish proper training and to delineate what activities may be required of trained custodial staff and under what circumstances.

Since most jails will not have a physician on duty in the facility 24 hours a day, seven days a week, protocols, standardized procedures and direct orders will be a crucial part of health care service delivery. Every effort should be made to ensure that practice and procedure are consistent with accepted medical and mental health professional standards and that scope of practice is adequately covered.

If inmates are used to provide janitorial services in health care areas, safeguards must be available for protecting the confidentiality of patients and records as well as for the protection of the working inmate (e.g. protection against exposure to communicable disease). The "rule of thumb" for jail administrators and the health authority is to avoid using inmates if safeguards cannot be developed.

Written policy should provide that inmates are not used for the following duties:

1. performing direct patient care services;
2. scheduling health care appointments;
3. determining access of other inmates to health care services;
4. handling or having access to surgical instruments, syringes, needles, medications, health records; or,
5. operating equipment for which they are not trained.

If inmates are used for cleaning medical or mental health housing units or lab areas, it is important that supervision and training be provided and that special procedures are used for proper handling of infectious wastes, contaminated laundry and other unique problems associated with such areas. The keys to inmate labor in health service delivery are:

1. adequate training in proper procedures;
2. proper supervision; and,
3. appropriate security measures.

If the facility/system administrator determines that a Type I facility will, provide health care services, the health authority may be the county health officer or a contract physician, such as an emergency department physician. Together with the facility administrator, this physician will decide how to provide services. Procedures that require physician approval, if provided by non-licensed staff in Type I or other jails, are:

1. delivery of prescription medications;
2. monitoring inebriates in sobering cells (**Section 1056, Use of Sobering Cell;** and **Section 1213, Detoxification Treatment**);

3. management of pregnant women and lactating women who will remain in the facility for more than 24 hours (**Section 1241, Minimum Diet;** and **Penal Code Section 4023.6**);
0. treatment of persons suspected of having a lice infestation (**Section 1212, Vermin Control**);
0. management of persons confined to safety cells (**Section 1055, Use of Safety Cell**);
0. performing the receiving screening health assessment (**Section 1207, Medical Receiving Screening**);
0. application of emergency first aid and the contents of the first aid kit [**Section 1220, First Aid Kit(s)**];
0. any medical procedure that under usual situations would require medical supervision such as medical diets; and,
0. use of prolonged restraints (**Section 1058, Use of Restraint Devices**).

1205. Medical/Mental Health Records.

( ) The health authority shall maintain individual, complete and dated health records which shall include, but not be limited to:

(0) receiving screening form/history;
(0) medical/mental health evaluation reports;
(0) complaints of illness or injury;
(0) names of personnel who treat, prescribe, and/or administer/ deliver prescription medication;
(0) location where treated; and,
(0) medication records in conformance with Section 1216.

(a) The physician/patient confidentiality privilege applies to the medical/mental health record. Access to the medical/mental health record shall be controlled by the health authority or designee.

The health authority shall ensure the confidentiality of each inmate's medical/mental health record file and such files shall be maintained separately from and in no way be part of the inmate's other jail records. The responsible physician or designee shall communicate information obtained in the course of medical/mental health screening and care to jail authorities when necessary for the protection of the welfare of the inmate or others, management of the jail, or maintenance of jail security and order.

(a) Written authorization by the inmate is necessary for transfer of medical/mental health record information unless otherwise provided by law or administrative regulations having the force and effect of law.

(a) Inmates shall not be used for medical/mental health record keeping.

Guideline: Complete, accurate and dated health care records are vitally important. Clarity and completeness of medical records will enhance efficient service delivery and provide documentation in the event of litigation or inmate complaints relative to health care.

Contents of Health Care Records: Medical and mental health information should be kept for every inmate assigned to a housing area. In instances where there has been no "health care encounter," this record may include only the receiving screening form **(Section 1207, Medical**

Receiving Screening). The individual health record ideally contains all information relative to the inmate who receives health services, from receiving screening through medical and mental health evaluations, sick call, medications, and contacts with health care staff. In addition, a complete record includes information such as: the name and title of the person documenting information; laboratory tests; results of X-ray and diagnostic studies; signatures and titles of each person providing care; consent and refusal forms; discharge summary of hospitalizations; place, date and time of health service encounters; and health service reports from any dental, psychiatric or other consultation.

While the receiving screening form is included in the medical records, it is also a custody document and is found in custody records as well. Some systems develop the screening instrument as a "multiple copy" form for this distribution. The screening form itself is usually based on inmate self-report and staff observations. Follow-up screening or intervention by health care staff is confidential within the medical record. The receiving screening form is administered as part of the intake process and is often completed by trained custodial staff pursuant to a procedure approved by the responsible physician. Some larger faculties may utilize licensed health care staff to complete the form, but where this occurs, it does not necessarily imply that it is a confidential health care document. Its purpose is to detect problems that might require immediate referral to an emergency room or hospital for a clearance. It may also lead to segregation or separation within the facility for safety reasons, or might influence classification and housing. If health care staff completes the receiving screening, and if the screening form itself is not forwarded to custody, then information needed for proper classification, housing and management must be communicated to custody.

Even in jails without in-house health care staff, when inmates receive medical or mental health care outside the facility, it is beneficial to maintain a record of the inmate's complaint, the means and manner of treatment as well as the location of treatment. In addition to maintaining their own record of treatment, it is recommended that the doctor or hospital treating the inmates at an outside location send the jail a summary, directing the follow-up care to be rendered on-site. Some facilities have found it helpful to place such information in a binder or health folder that is separate from the custody file, but available to custody staff for follow-up.

In keeping with Subsection (a)(3) of this regulation and **Section 1211, Sick Call**, it can prove extremely helpful to retain sick call slips or sick call sign-up sheets. Clear policy and procedures calling for permanent filing of request forms affords early protection against charges of impeded access to care or ignoring health care needs. In some facilities, the sick call slip is added to the inmate's medical record and includes a space for the health provider to note date, time, initials and disposition or treatment, directly under the inmate's request. Such slips do not take the place of actual charting by the provider(s); however, these slips afford excellent documentation that health care personnel are addressing inmate needs.

Records documenting the administration of prescription medications, pursuant this regulation and **Section 1216, Pharmaceutical Management**, are an essential part of the individual medical file. This record should include: the name of the person administering or delivering the drug; the doctor prescribing it; times of delivery; and occasions when the drug was not given according to schedule, with reasons why not. It is also good medical practice to keep records on any over-the-counter medication given to an inmate. While such procedures can increase the record

keeping tasks, they may also be instrumental in monitoring patterns of requests, contraindications, patterns of over-medicating and prevent hoarding and trading drugs.

Every inmate has a right to refuse treatment except when an actual life-or-limb-saving emergency exists. If the inmate were unconscious, then treatment should be provided; however, if the person is awake and refusing treatment, the same principles exist for obtaining consent as would prevail in the community. If a condition is deteriorating due to the inmate's refusal, or an inmate appears incompetent to make a decision, procedures should be in place to institute further review by the court. This does not preclude arrangements for advanced directives or "do not resuscitate" orders when appropriate. Policies to address such situations should be carefully written and applied, with the assistance of legal counsel.

For each inmate receiving psychotropic medications pursuant to **Section 1217**, **Psychotropic Drugs,** the facility must maintain individual, complete and dated health records, including documentation of consent for such medications. In most instances, the record consists of a written consent signed by the inmate and the prescribing physician. If the inmate refuses to sign the consent form, but understands the nature and effect of the medication, this should be documented. Methods to confirm and document the inmate's understanding can include placing the unsigned form in the record with a notation regarding the date and time of the discussion with the inmate or a written notation by the physician in the progress notes.

Confidentiality: Facilities must stay current with and adhere to laws related to medical records management, including retention and disclosure. Health care records must be under the control of the health authority and must be kept separate from detention records. Record file systems may differentiate pregnant inmates and juveniles from others.

Maintaining health care records in a detention facility raises complex legal and ethical issues because medical and mental health records are protected by separate regulations. The health authority should develop written policies describing:

- who is entitled to review the inmate's health record;
- under what conditions the records must be released;
- how and when records should be transported when an inmate is transferred between facilities (discussed at greater length below and within the guidelines for **Section 1206, Health Care Procedures Manual**; and,
- what information is provided to nonmedical personnel for the protection of the welfare of inmates, staff or the facility.

A responsible clinician or medical records administrator, designated by the health authority as custodian of the record, must control access to inmate medical and mental health records pursuant to **Section 56 et. seq**. of the **Confidentiality of Medical Information Act, California Civil Code**. Inmates have the right to confidentiality. The physician/patient confidentiality privilege applies to the medical/mental health record. All information gained through evaluation and treatment must remain confidential except as discussed in this section.

Confidentiality also refers to the ethical and legal obligation of psychotherapists to hold any information imparted to them during treatment in confidence. Privilege is the right and authority

to exclude from evidence in a legal proceeding any confidential communication protected by statute. Like medical records, psychiatric records are protected by the psychotherapist-patient privilege, pursuant to **Section 1010 - 1028 of the California Evidence Code**. Confidentiality and security of the jail mental health record should be maintained in accordance with **California Welfare and Institutions (W & I) Code Section 5328**. Where medical and mental health records are kept in a single file or jacket, it is helpful to separate them for easy distinction.

Generally speaking, an inmate's record may be disclosed, with the inmate's authorization, under the following circumstances:

- to any person designated in writing by the inmate provided that the professional person (e.g., physician, licensed psychologist or licensed clinical social worker) in charge of the patient gives approval; or,
- to any person designated in writing by a juvenile's parent or guardian, or an adult inmate's guardian or conservator.

The inmate's record may be disclosed, without the inmate's authorization, under the following circumstances:

- to the health care professionals who are members of the health care team responsible for the inmate's care;
- to a family member, but the information disclosed should be limited to the inmate's residence in the facility, his/her discharge or death. (This is usually accomplished by custody rather than health personnel.);
- to jail custody staff with information that a specifically identified inmate is:
  - suicidal;
  - homicidal;
  - a clear custodial risk;
  - presenting a clear danger of injury to self or others;
  - gravely disabled;
  - receiving psychotropic medications;
  - a communicable disease risk; or,
  - in need of special handling.
- to the local health officer when an inmate is part of a communicable disease investigation; or,
- to the presiding judge of the court issuing a subpoena duces tecum if the privilege has been waived (pursuant to **Sections 1010 - 1028 of the California Evidence Code**), or if the judge, after reviewing the material, orders compliance. If the defense or the prosecution requests to review the inmate's record without the inmate's consent, the custodian of record shall take the request to the judge issuing the subpoena for a determination of the relevance of the disclosure.

There are certain circumstances in which a duty to share information overrides the duty to keep a communication confidential. This includes the Tarasoff duty, the so-called "duty to warn" or otherwise suitably protect potential victims of violent crimes. There are specific requirements under the Tarasoff decision that balance confidentiality against the duty to protect, and the reader should discuss questions with their county counsel. In addition, a therapist or medical

professional must report information of suspected child or elder abuse to the appropriate agency and must report knowledge of abuse of the handicapped, domestic violence and other situations required by law. This information must be reported to the appropriate agency and should be reported to the facility manager if it endangers staff, the inmate, or others in the jail.

This regulation requires written authorization by the inmate to transfer health records or information, unless otherwise provided by law or administrative regulations having the force and effect of law. An inmate's health record or summary should follow the inmate in order to assure continuity of care and to avoid duplication of tests and examinations. Release of medical summaries to health care staff of the facility to which the inmate is being remanded does not require inmate authorization.

HSC Section 121361 requires facilities to provide advance notification to the local health officer and the receiving facility when transferring or releasing an inmate with active tuberculosis disease to another jurisdiction. An example of a notification format for jails is in **Appendix 2**. Administrators should consult with their local health department for the latest information on implementing this statute when developing policies and procedures in this area.

Regulations also require procedures to implement transferring a medical information summary for each inmate transferred to a facility in another jurisdiction. Administrators may find it beneficial to implement similar procedures for transferring inmates among facilities within their systems. (Please see **Section 1206, Health Care Procedures Manual**; **Section 1206.5, Management of Communicable Diseases in a Custody Setting**; and **Appendix 2** for an example summary form and procedures)

The automation of health records can improve their efficiency and availability. The benefits for medical, mental health, pharmaceutical and dental services can be enormous, especially in larger facilities where the number of health contacts is voluminous. As more jails develop automated record systems, it is recommended that they include health and pharmacy records among those automated. When this is done, it is critical that code access restrictions and other available provisions be used to limit access to medical records and properly ensure confidentiality and security. As with a non-automated system, the medical receiving screening form, documenting both the positive and negative inmate responses, must be available to: custody staff for management and classification purposes; to health care staff using and monitoring automated systems; and to health and Board of Corrections inspectors who are required to verify compliance with regulations. The capacity to review automated records for quality control is an essential design consideration. Due to the complexity of medical records laws and the frequency with which they change, it is advisable to regularly refer to current legal references.

1206. Health Care Procedures Manual.

The health authority shall, in cooperation with the facility administrator, set forth in writing, policies and procedures in conformance with applicable state and federal law, which are reviewed and updated at least annually and include but are not limited to:

(a) summoning and application of proper medical aid;

(b) contact and consultation with private physicians;

(c) emergency and non-emergency medical and dental services, including transportation;
( ) provision for medically required dental and medical prostheses and eyeglasses;
( ) notification of next of kin or legal guardian in case of serious illness which may result in death;
( ) provision for screening and care of pregnant and lactating women, including postpartum care, and other services mandated by statute;
( ) screening, referral and care of mentally disordered and developmentally disabled inmates;
( ) implementation of special medical programs;
( ) management of inmates suspected of or confirmed to have communicable diseases;
( ) the procurement, storage, repackaging, labeling, dispensing, administration/delivery to inmates, and disposal of pharmaceuticals;
( ) use of non-physician personnel in providing medical care;
( ) provision of medical diets;
( ) patient confidentiality and its exceptions;
( ) the transfer of pertinent individualized health care information, or individual documentation that no health care information is available, to the health authority of another correctional system, medical facility, or mental health facility at the time each inmate is transferred and prior notification pursuant to Health and Safety Code Sections 121361 and 121362 for inmates with known or suspected active tuberculosis disease. Procedures for notification to the transferring health care staff shall allow sufficient time to prepare the summary. The summary information shall identify the sending facility and be in a consistent format that includes the need for follow-up care, diagnostic tests performed, medications prescribed, pending appointments, significant health problems, and other information that is necessary to provide for continuity of health care. Necessary inmate medication and health care information shall be provided to the transporting staff, together with precautions necessary to protect staff and inmate passengers from disease transmission during transport.
( ) forensic medical services, including drawing of blood alcohol samples, body cavity searches, and other functions for the purpose of prosecution shall not be performed by medical personnel responsible for providing ongoing care to the inmates.

Guideline: The health authority is responsible for developing, disseminating and at least annually, reviewing and updating the Health Care Procedures Manual. The health authority must work closely with the facility administrator to ensure that the policies and procedures of the health care system reflect and complement the general policies and procedures of the facility. When health care polices have implications for public health, the facility health authority is encouraged to consult with the local health officer (e.g., **Section 1206.5, Management of Communicable Disease in a Custody Setting**.) A related regulation, **Section 1029, Policy and Procedures Manual,** requires facility administrators to assure that policy and procedures address all applicable regulations, that they are available to staff and that they are reviewed and updated at least annually. This overall requirement for an annual review and update would apply to health care policy and procedures, as well as those more directly associated with custody.

Health policies define both the actual delivery of service and the facility's legal responsibility; therefore, care must be taken to be realistic and explicit about each policy and its attendant

practice. Policies and procedures that are clearly and completely expressed and properly carried out are the best protection against liability.

Because custody and health staff works closely together, the facility administrator should ensure that custody staff is kept aware of health policies, procedures and revisions that have an impact on them. Similar processes need to be in place for health care staff to stay current with custody policies and procedures. A system should also be established to resolve conflicts between custody and health personnel.

The health care procedures manual, and the related processes and programs, must be reviewed at least annually to ensure that they continue to reflect practice and meet the needs of the facility. An effective method for documenting each review and revision includes the date and the signature of the reviewer. Additionally, there should be a process for disseminating changes and making sure all staff understand and implement revisions. Custody staff needs input into the review of health care procedures along with the health personnel, since they work with inmates and carry out the procedures on a day-to-day basis. Their early input will help ensure that policies and procedures do not create unnecessary conflicts with custody operations.

When there are multiple facilities within the same system, similar functions should be governed by the same policies and procedures unless there are some compelling reasons to the contrary. However, it is essential that policies and procedures reflect actual practice in individual facilities; thus, where differences exist among facilities, this should be reflected in policy.

The most effective manual will have policy and procedure, not only for every health regulation, but for other matters not covered in regulations as well. The manual should be a comprehensive document that addresses all areas relevant to providing health care in the jail system, regardless of whether those areas are governed by regulation.

Subsection (a) emphasizes the importance of having clear written procedures for applying first aid within the facility. Policies and procedures should assure that staff understand their responsibilities with respect to providing first aid and have the necessary skills and training to perform these responsibilities [**Section 1220, First Aid Kit(s)**].

As noted in **Subsection (b)**, policy and procedures relative to consultations with private physicians are needed. Are they allowed in the facility? Are inmates taken out to see private doctors? What procedures are to be used? How is transportation provided? Are there any costs to the inmate?

An inmate's illness may require the services of a specialist, so written agreements with consultants in the major health care specialties should be developed in advance. Such agreements, if reflected in policy and procedure, can expedite the delivery of special services and minimize any disruption of normal operations for both health and custody personnel. Sources of assistance for physically ill, mentally ill, retarded or developmentally disabled inmates should be included in the manual and posted in appropriate places in the facility for easy reference and referral.

Provisions for private physicians in **Subsection (b)** overlap with **Subsection (f)**, which requires screening and care of pregnant and lactating women, including postpartum care and other services mandated by statute. All facilities that house female inmates need policies and procedures relating to the special health care needs of females. It is important that the policy define inmates' access to gynecological/obstetric services, whether inmates are taken out of the facility or these specialists come in, and that the facility is in compliance with **Penal Code Section 4028** related to abortion services. That Penal Code section requires that "the rights provided for females by this section shall be posted in at least one conspicuous place to which all females have access."

Penal Code Section 4023.5 requires family planning services, allows continuation of birth control measures prescribed by the inmate's physician and requires that personal hygiene products be provided. Policy and procedures are especially important regarding the continuation of female inmates on their prescribed oral or injectable contraceptives. These require regular and continuous dosages to be effective; disruption of dosages can create problems after release. **Penal Code Section 4023.6** requires the availability of pregnancy testing and allows the inmate to obtain medical services from the physician of her choice, at her expense. The statute also requires these rights be posted in a location where female inmates are aware of them. It is important that policies and procedures describe the facility's approach to these matters. Each of these Penal Code sections applies to jails authorized to confine women for more than 24 hours.

Medical diets **(Section 1248)** may be necessary for some pregnant and lactating women. Custody and health staff must be aware of the concerns that pregnant inmates and inmate mothers may have when separated from their families. It is advisable for the health authority and the facility administrator to provide staff training which will increase awareness of pregnancy related problems and procedures for alerting appropriate staff when an inmate needs counseling or support services.

Subsection (d) requires procedures for providing medically required dental and medical prostheses and eyeglasses. In part, this subsection is also addressed in **Section 1200, Responsibility for Health Care Services**, and **Section 1215, Dental Care**.

Subsection (e) requires policies and procedures to notify the inmate's family of serious illness that may result in death. These procedures should be developed with custody staff, as there are frequently security concerns that overlap with health care issues and the notification is typically done by custody.

Subsection (g) references the importance of procedures for screening, referral and care of mentally disordered and developmentally disabled inmates. These issues are discussed in **Section 1052, Mentally Disordered Inmates; Section 1057, Developmentally Disabled Inmates;** and **Section 1217, Psychotropic Medications**. (See **Guidelines for Title 15, Program and Procedures Standards** for a discussion of **Sections 1052, Mentally Disordered Inmates and 1057 Developmentally Disabled Inmates**, together with information on how to access the Regional Centers for Developmentally Disabled.)

Subsection (h) requires that any special medical programs operate with written policies and procedures. Special programs may include "time-limited" pilot projects to assess revised

procedures and special programs that may not be routinely considered part of the health care program. **Subsection (i)** emphasizes the importance of having procedures for managing communicable diseases as outlined in **Section 1051, Communicable Diseases; Section 1206.5, Management of Communicable Diseases in a Custody Setting;** and **Section 1207, Medical Receiving Screening**. **Subsection (j)** and **Section 1216, Pharmaceutical Management** require procedures for pharmaceutical management, including medication disposal. **Subsection (k)** requires written policy and procedure for the use of non-physician personnel to deliver health care services. This use must be consistent with the law, as discussed in **Section 1203, Health Care Staff Qualifications**. In addition to the **Subsection (l)** requirement for written procedures, medical diets are also discussed in **Section 1248, Medical Diets**. **Subsection (m)** requires procedures for assuring the confidentiality of inmate records, as outlined in **Section 1205, Medical/Mental Health Records**.

Transfer Health Care Information: The requirements of **Subsection (n)** apply to all Type I, II, III and IV facilities where inmates are housed and the "intake/release" functions occur. A jail's procedures should be appropriate to the facility. For example, in Type I facilities, a copy of the medical receiving screening may be the only information available, and would be the "standardized format" which should accompany the inmate to another jail system. Other Type I facilities may hold inmates for longer periods of time, house inmates who are on medications and have other information that should be relayed. **Subsection (n)** requires policies and procedures to forward pertinent health care information to the health authority in another correctional system, or a medical or mental health facility when an inmate is transferred. When transferring an inmate with known or suspected active tuberculosis, prior notification must occur in accordance with **HSC Sections 121361** and **121362**. Intake procedures at the receiving facility must assure the information is given to the appropriate health care staff. This requirement applies to all inmates and is broader than the statutory requirement to notify the local health officer and medical staff in the receiving facility when transferring an inmate with active tuberculosis disease (**Section 1205, Medical/Mental Health Records,** and **Section 1206.5, Management of Communicable Diseases in a Custody Setting**).

The intent of this subsection is that the information will be in an established, readily identifiable format and accompany the inmate at the time of transfer. It should immediately alert staff at the receiving facility that there are medical considerations related to the inmate; it should also improve the continuity of health care services and reduce the costs of unnecessarily replicating tests and evaluations. The transferred health care summary should also alert the receiving facility if the sending institution has no health information on the inmate so that appropriate screening can occur as soon as possible. The transfer information should not only include current diagnosis and treatment, but should also indicate if there has been an exposure to a communicable disease that requires follow-up observation and treatment.

Appendix 2 includes a sample transfer form that has been adapted from one developed by local practitioners and used in several jurisdictions since this subsection took effect in 1991. Additionally the California Tuberculosis Controller Association (CTCA) has developed "Guidelines" and reporting forms to use when notifying their local health officer-TB Controller about inmates with TB. This information is located on their website at http://www.ctca.org. Facility health care staff is encouraged to work closely with their local health department to assure proper reporting and communication.

The forms and procedures in this appendix were adopted by an interagency task group as the recommended format for correctional facilities in California.[5] **Appendix 2** outlines issues that need to be addressed when developing policy and procedures for facilities. The information on page two should be printed on the outside of the sealed envelope that contains confidential medical information. Any information needed for the safe transport of the inmate should be noted on the outside of the envelope and readily available to the transporting staff who need to be aware of any medication needs and special handling instructions during the transport itself. The third page of this appendix is an example of a transfer summary. Additional health care information may be included as appropriate to the situation. It is critical that facilities include their name, address and contact number at the top of the form, so that health care staff at the receiving facility know where the information originated and have a telephone number to request clarifying information.

Policies and procedures for transferring health care information need to be developed with the active participation of custody staff. The information is to accompany the inmate during transport, with facsimile transfer used to send supplemental information to the receiving facility and for backup. Before utilizing a fax, health care staff should know that the faxed information would be handled and distributed appropriately at the receiving facility. (As discussed earlier, statute requires prior notification when transferring an inmate with known or suspected active TB.)

For the procedures to be effective, health care staff must have sufficient notice of the pending transfer to allow time to prepare the materials. Health care staff should promptly follow-up with the receiving facility in the event of an emergency or unscheduled transfer. Additionally, transport officers must be aware that they need the information before leaving with the inmate. Intake staff should ask for the information on incoming inmates and have procedures in place to assure that it is promptly delivered to health care personnel. A breakdown in communication and procedures at any point can unnecessarily expose staff and inmates to health risks, result in additional costs and increase the liability of the facility if an inmate's care is disrupted.

Facility and health care managers can learn a great deal about how information is transferred and received in their facilities by periodically auditing their internal procedures. These audits provide information that enables managers to take corrective action before there are major problems. **Appendix 3** outlines facility audit and evaluation procedures that were developed and tested by the interagency task group. The audit involves both custody and health care staff and managers to determine the frequency and extent of the reviews. Audit information may be useful in health and Board of Corrections inspections to document compliance with the regulation.

Subsection (o) prohibits on-site health care staff providing direct and ongoing inmate health care from performing forensic services for the purpose of prosecution. While it can be tempting to have on-site health care staff collect certain specimens for evidence, the benefits of the convenience may be outweighed by the disadvantages. Not only is there a role conflict by requiring health care staff to become directly involved in prosecution, but there is also

[5] The recommended transfer forms and procedures were developed by a 1994-96 interagency task group including the State Department of Corrections, California Youth Authority, Department of Health Services, California Conference of Local Health Officers, county jails and the Board of Corrections.

competition for staff time. The time demands for health personnel to perform evidence collection and examinations are compounded by the ensuing time requirements for related court appearances, all of which directly impacts availability to perform sick call and other essential services. Alternatives for accomplishing necessary forensic functions may include use of a local emergency department or clinic. Large facilities may be able to justify hiring or contracting with a medically trained individual who is separate from the treatment team. This subsection does not prohibit using onsite health care staff from collecting DNA samples as required by **Penal Code 298.1** and **Section 1059, DNA Collection, Use of Reasonable Force**; however, statute allows the use of custody and medically trained staff, such as phlebotomists, as an alternative.

There is some leeway that may allow health providers to participate in court-ordered examinations under some circumstances. Each circumstance should be carefully evaluated with the following questions in mind: (1) Is the inmate agreeable to the procedure? (2) Will participation of the health provider jeopardize the future therapeutic relationship with the inmate? (3) Is the examination likely to be detrimental to the inmate in any way? and (4) Will performance of this examination detract from completion of the provider's primary health care duties, both during the examination itself and as the result of any subsequent required court appearances? The treating health care staff should participate in court-order services only to the extent that they can do so without compromising the relationship with the inmate-patient and without detracting from the central objective of providing health services.

Examples of possible situations in which a jail health provider might participate in a court-ordered examination include:

1. examination of an inmate who has been a victim of assault to document, and treat injuries, such as contusions and abrasions;[6]
2. testing for blood-borne pathogens following an exposure incident, if the inmate does not object;
3. paternity testing or other examinations necessary for court proceedings, if the inmate does not object; and,
4. tests ordered as a condition of probation.

Some inmates, realizing that court-ordered testing will inevitably be completed, prefer to have it done in the relative privacy of the jail, rather that being publicly transported to a hospital emergency department. In such cases, conducting the procedure at the jail site is not only efficient, but also considerate of the inmate's feelings. By carefully reviewing each situation, health care staff can work cooperatively with the courts as long as professional roles and motivations remain clearly understood. When in doubt about the advisability of performing a court-ordered examination, it is better to refer the matter to a setting that does not involve the inmate's regular health care provider.

1206.5. Management of Communicable Diseases in a Custody Setting.

(a) The responsible physician, in conjunction with the facility administrator and the county health officer, shall develop a written plan to address the identification,

[6] It is recommended that victims of sexual assault be referred to an emergency department fully equipped to provide examination, treatment, and support services.

treatment, control and follow-up management of communicable diseases including, but not limited to, tuberculosis and other airborne diseases. The plan shall cover the intake screening procedures, identification of relevant symptoms, referral for a medical evaluation, treatment responsibilities during incarceration and coordination with public health officials for follow-up treatment in the community. The plan shall reflect the current local incidence of communicable diseases which threaten the health of inmates and staff.

( ) Consistent with the above plan, the health authority shall, in cooperation with the facility administrator and the county health officer, set forth in writing, policies and procedures in conformance with applicable state and federal law, which include, but are not limited to:

- **(0) the types of communicable diseases to be reported;**
- **(0) the persons who shall receive the medical reports;**
- **(0) sharing of medical information with inmates and custody staff;**
- **(0) medical procedures required to identify the presence of disease(s) and lessen the risk of exposure to others;**
- **(0) medical confidentiality requirements;**
- **(0) housing considerations based upon behavior, medical needs, and safety of the affected inmates;**
- **(0) provisions for inmate consent that address the limits of confidentiality; and,**
- **(0) reporting and appropriate action upon the possible exposure of custody staff to a communicable disease.**

Guideline: Jail populations tend to be more disease prone and may have higher incidences of infectious diseases than the population at large. Diseases with which inmates may be infected include: tuberculosis; sexually transmitted diseases; hepatitis; HIV/AIDS; measles; meningitis; and others that pose serious management issues for both custody and health care staff. This regulation calls for a written plan to address the identification, treatment, control and follow-up management of communicable diseases. Because there are wide ranges of communicable diseases that can affect inmate populations and incidence rates vary among jurisdictions, this regulation directs that facilities have a plan that responds to those infectious diseases that are most prevalent in their local areas. The regulation specifies that the plan must reflect "current" local incidence of communicable diseases. To maintain the plan as current, there must be a plan for regular review, update and response to emergent diseases. The DHS website includes specific references to a variety of communicable diseases, along applicable reporting forms, etc. (http://www.dhs.ca.gov/ps/dcdc/dcdcindex.htm). The plan should also identify key custody and health care staff positions that are responsible to ensure that the plan is implemented and that there is timely communication to resolve problems.

The communicable disease plan is intended to offer a broad overview of a multifaceted approach to managing communicable diseases within the facility. This plan is a central "hub" which assures that important components are in place, referencing other procedures for details of implementation. The plan should identify which persons or agencies have responsibility for implementing each area. **Appendix 4** is a suggested outline of areas to consider when developing a facility-specific plan. Jail physicians vary with respect to their expertise in public health issues; likewise, health officers vary in their familiarity and involvement with jails. It is important to schedule regular discussion among the concerned parties in order to develop an

effective plan and maintain working relationships that assure that the plan remains "current" and that its provisions are implemented.

This regulation does not apply to court holding facilities, which are essentially extensions of longer term jails. It also does not apply to temporary holding facilities, which are only required to screen inmates pursuant to **Section 1051, Communicable Diseases** and take appropriate action to transport and obtain medical services. With these exceptions, the requirement for a plan applies to all types of jails. In Type I facilities, the plan may be that the facility does not keep, but immediately transfers prisoners suspected of having a communicable disease. This plan must be in writing. Facilities which transfer "immediately" must still pay close attention to **Section 1051, Communicable Diseases**, which requires procedures to segregate any inmate suspected of having a communicable disease, pending that transfer. Segregation alone may not be sufficient to prevent the spread of certain diseases, particularly active tuberculosis and follow-up action may be required (see discussion below).

Although Type IV facilities have historically required little or no specific medical clearance, they should, at a minimum, consider a requirement for tuberculosis testing and clearance prior to acceptance of new inmates. Disease transmission can occur in dormitories even though inmates may be at work away from the facility during the day. In some jurisdictions, inmates may enter a Type IV facility without having a receiving screening completed at a higher-level jail in the system. In those instances, the medical receiving screening must be completed prior to housing in the Type IV facility (**Section 1207, Medical Receiving Screening**).

The intent of this regulation is that the responsible physician, facility administrator and the local health officer will collaborate in developing the communicable disease plan, as each has a distinct role. The facility administrator has ultimate responsibility for the facility policies, procedures and budget. The designated responsible physician (**Section 1200, Responsibility for Health Care Services**) has responsibility for clinical services and the control of communicable diseases within the facility. The health officer's public health responsibilities overlap with concerns of the jail administrator and the responsible physician, as the jail population reflects the health conditions of the surrounding community and infectious inmates have an impact on public health upon release. In addition, inmates who have transferred from other jurisdictions may carry infections that are otherwise not common locally. The local health officer maintains statistics on communicable diseases reported in the county. This information is relevant to the development of procedures and prioritization of each jurisdiction's resources toward communicable disease control in the jail.

The primary priorities of the health administrator and responsible physician are to prevent the spread of disease within the inmate population, and to treat those conditions that demand prompt intervention to preserve the health of the inmate. Local health officials may recognize that the jail offers a valuable opportunity to conduct other screening or educational programs. At times, there may be debate as to whether programs should be funded by the health department or the sheriff/police department. In such instances, it may be helpful to analyze the program from the point-of-view of an insurance company. If the proposed program makes actuarial sense in reducing morbidity, mortality, or costs of inmate health care for the period of time of a typical incarceration, then consideration should be given to including the program in jail health care services. If, on the other hand, the major benefit is to the community as a whole over an

extended timeframe, then it would be considered a health department responsibility. In some instances the plan may define shared responsibilities. When jail health care services are obtained on a private contract basis, these issues should be anticipated through the "request for proposals" and clarified from the beginning in the written agreement.

Health departments are encouraged to include jail inmates under their public health programs whenever possible. At times, such as for communicable disease screening or surveillance, it may be useful for health departments to deploy staff to the jail site. At the same time, the facility administrator's obligations with respect to communicable disease programs are first and foremost to address institutional safety. In the event of a communicable disease outbreak, the on-site involvement of local health department staff can provide valuable assistance in determining and implementing disease control measures. While the jail's physician is responsible for the clinical treatment of inmates, the local health officer maintains statutory authority to intervene in specific ways to control the spread of disease. A clear understanding of when and how this might occur will prevent confusion or conflict in cases of overlapping roles.

In addition to local resources, there are several other agencies that can be of assistance. The State Department of Health Services Communicable Disease Control Division is a resource on communicable diseases and can recommend treatment strategies and suggested formats for developing and evaluating effective communicable disease programs. The National Centers for Disease Control and Prevention (CDC) can provide additional comprehensive information and treatment guidelines. The CDC has published two useful documents: **Controlling TB in Correctional Settings** and **Prevention and Control of Tuberculosis in Correctional Facilities.** Another comprehensive reference book on communicable disease control is the **Control of Communicable Diseases Manual** (James Chin, ed., 17th edition APHA,2000). California specific information is available from the California Department of Health Services, Division of Communicable Disease Control (http://www.dhs.ca.gov/ps/dcdc/dcdcindex.htm).

The regulation specifies that the plan outline how the identification, medical evaluation, treatment, control and follow-up management of communicable diseases will occur. Roles and relationships among facility staff and the local health officer should be discussed. The plan will require compatible policies and procedures to be implemented.

The communicable disease management plan should outline the generally expected treatment strategies that will be followed in dealing with an identified disease, together with any educational or preventive services that may be available. For instance, the facility may wish to make a policy statement as to its commitment toward providing preventive antibiotic therapy to inmates who are found to have latent (noninfectious) stages of tuberculosis. Likewise, immunization strategies may be undertaken in facilities experiencing particular problems with diseases such as measles or meningitis. The plan should clarify who is responsible, both clinically and fiscally, for treatment approaches that may be over and above the usual routine. Policy should address procedures for testing inmates for diseases such as Hepatitis B, Hepatitis C, or HIV, on either a voluntary or involuntary (when allowed by law) basis when relevant to evaluating an exposure incident.

Appendix 5 discusses the critical issues in several communicable diseases. Its purpose is to address certain diseases that are of special concern to jails, either due to their common

occurrence, seriousness, or potential for spread to inmates and staff. This list is not all-inclusive; each facility is advised to work with their local health officer to assure that its communicable disease plan accounts for conditions of concern locally. Neither is this section intended to substitute for a medical textbook; instead, it will emphasize some features of each listed disease to establish relevance for the detention setting.

It should be noted that some infecting organisms have multiple mechanisms of transmission (e.g., Hepatitis B virus may be spread via blood, sexual contact, maternal-child, injury on a contaminated sharp instrument, or contact with fluids from a draining wound). Therefore, precautions need to take all applicable potential exposure conditions into account.

Although the spread of sexually transmitted diseases (STDs) is not thought to commonly occur in jail settings, several are mentioned here as a reminder that jail inmates are often at risk for acquiring such infections prior to booking. A high index of suspicion for STDs will favor early detection and treatment. Where resources permit and prevalence rates are high, some jails have offered targeted screening of inmates at particular risk, such as those arrested for prostitution.

Many other communicable diseases not mentioned in this section may pose significant problems for individual facilities. Examples include mycoplasma pneumonia, Legionella, streptococcal pharyngitis, pneumococcal disease, and others. Any unusual clustering of communicable diseases in a facility must be reported to the local health officer. Crowded conditions may contribute to the likelihood of transmission of diseases that are not ordinarily considered highly infectious.

Identification includes aspects of **Section 1207, Medical Receiving Screening**, and **Section 1051, Communicable Diseases**, which require that an initial screening occur and that inmates with suspected communicable diseases be separated from the general population until a medical assessment is done. Because the incidences of communicable diseases and the available resources to address them vary widely among geographic locations, it is important that local screening procedures be consistent with the overall plan and reflects the local incidence of communicable diseases. Consideration should be given to timely placement in negative pressure isolation rooms in the facility or a community setting when clinically indicated. Policies and procedures for all facilities must describe how receiving screening is done to identify contagious diseases and to prevent housing an infectious inmate in the general population. It is critical that the plan be consistent with jail policy, realistic and can be implemented.

Although it is appropriate to ask inmates directly about certain diseases, such as HIV or tuberculosis, screening approaches should also include questions and observations about key symptoms. For instance, asking about coughs of greater than three weeks duration, weight loss, fever and night sweats will yield valuable clues to suspecting tuberculosis in a person who might otherwise deny having the disease. Intake staff needs to be trained in screening procedures and in recognizing symptoms of critical diseases. In order to successfully separate inmates with communicable diseases from the general population, intake and other staff must maintain a constant and high index of suspicion and vigilance.

While this regulation primarily addresses identification of communicable disease from the standpoint of receiving screening and recognition of early symptoms of illness, the plan should

also establish additional medical screening procedures that would be implemented by health care staff, together with expected timeframes. This could include a more detailed medical history, physical examination and specific screening tests. Again, the extent to which such testing is feasible and warranted will vary according the type of detention facility, resources, and disease incidence rates characteristic of the population. With respect to testing, at a minimum, screening for tuberculosis infection through skin testing and/or x-rays to identify active pulmonary TB is now standard practice for many facilities which house inmates for extended periods of time. The plan should identify timeframes for TB testing, medical evaluation and follow-up, as there have been institutional outbreaks of TB associated with delays in medical evaluation and diagnosis. Administrators should stay current with changing recommendations from the medical community. Resources such as the CTA, Centers for Disease Control and Prevention (CDC) and the Department of Health Services Tuberculosis Control Branch can provide up-to-date and authoritative guidance. Policy should consider methods for handling inmates who refuse to comply with treatment or testing for suspected communicable disease.

Communicable diseases may not be immediately identifiable, because some take months or even years to incubate before they are manifested. In some instances, staff may have contact with inmates prior to suspecting a contagious disease. In either case, staff will not know all inmates who have communicable diseases. Consequently, it is essential that staff of all local detention facilities constantly avail themselves of "standard precautions" to protect themselves from communicable diseases which are transmitted by blood or other substances, recognizing that these still do not protect against airborne transmission. Particular care should be taken to avoid exposure to blood-contaminated objects when searching inmates and their cells or rooms. **General Industry Safety Orders, Section 5193, Title 8 CCR,** require that facilities have policy and procedures for blood-borne pathogen control.[7]

Housing options and measures to control exposure within the facility should be discussed in the plan. All persons exhibiting symptoms or suspected to be carrying diseases must be segregated upon identification and then examined by medical staff. In Type I and other short term holding facilities the inmate must be separated from others, be seen by a doctor, or transferred to a county jail. Where transfer occurs, the transporting officer must notify the receiving facility of the health concerns. Once a positive determination has been made, the carrier may need to be quarantined and placed under special medical care. Provisions must be made for appropriate short-term and long-term housing options to address the range of possible isolation needs. While single-cell housing is sufficient for most communicable disease concerns, facilities need to have arrangements to quickly and effectively isolate cases of tuberculosis that are known or suspected to be in the active stage in an appropriate negative pressure room. Jails that have frequent needs for this type of respiratory isolation may choose to construct facilities capable of providing respiratory isolation, while others meet this need by establishing arrangements for off-site placement of the inmate. It is also necessary to determine how to handle the review of inmates' conditions so that inmates who have recovered sufficiently can be returned to general housing when medical segregation or separation is no longer necessary.

[7]Under the authority of the Division of Occupational Safety and Health (Cal-OSHA), Title 8 makes additional requirements related to communicable diseases (including Sections 3203, 5141, 5144, and 14301.) Relevant statutes relating to testing following exposure incidents include Health and Safety Code Sections 121050-121070, and Penal Code Section 7500.

Policy and procedure should require that medical staff inform custody staff of any special housing needs for medical reasons. Although the jail manager must be advised **(HSC Section 121070)**, custody staff may or may not be aware of the specific diagnosis of any individual inmate requiring such special housing. Custody staff should, however, be aware that certain individuals need particular levels of care. In addition, custody staff must be informed of any precautions they need to take for their own protection or that of others; both the medical and the operational policy and procedures manuals should reflect this information.

Housing persons with known or suspected tuberculosis ideally involves placement in a negative-pressure isolation room specially designed for that purpose.[8] Since many jails are not equipped for respiratory isolation, the inmate may need to be transported to another facility with adequate respiratory isolation rooms. Pending housing in an appropriately equipped room, a single cell is sometimes the only available temporary option. It should be recognized that tuberculosis organisms can circulate through ventilation ducts and certainly pass beyond bars separating inmates. Administrators should consider policies that require use of masks by inmates or respirators by staff while arranging for atmospheric isolation. Procedures should be in place for prompt action to remove persons with known or suspected active, contagious tuberculosis from any detention settings where they are placing others at risk of infection, even if transfer to a better equipped jail or to a hospital facility is necessary. Occasionally, the local health officer may order a non-adherent tuberculosis patient to the jail for treatment; in such instances, it is imperative that the facility is properly equipped to house such a commitment.

When inmates have communicable diseases, stringent sanitary conditions need to be imposed so that infected inmates practice careful personal hygiene and that others (staff and inmates alike) use appropriate protective equipment and take care to wash their hands after contact. Certain conditions, such as scabies and hepatitis, warrant special handling of clothing and linen which should be carefully separated from other institutional laundry, clearly marked and stored in sealed plastic or other special isolation bags until they are washed **(Section 1263, Clothing Supply and Section 1264, Control of Vermin in Inmate's Personal Clothing)**. Laundry personnel should observe careful personal hygiene when handling these items.

Medical follow-up within the facility and when appropriate, upon release, should be addressed by the plan and can be a particularly controversial area of discussion. The regulation is not intended to make the sheriff or chief of police responsible for medical follow-up after release to the community. However, effective treatment of several diseases, including tuberculosis and sexually transmitted diseases (STDs), may require that treatment continue in the community. Local health officers have an immediate stake in community follow-up from the standpoint of their public health responsibilities. This is also an area of concern to facility custody and medical administrators who will be responsible for untreated or partially treated persons readmitted to custody.

The follow-up options will vary by community. It is the intent of this regulation that jail systems work with their local health officers to identify ways to increase the likelihood that this follow-up will occur. This may include: providing the inmate with information prepared by the health

[8]Current recommendations from the National Centers for Disease Control and Prevention and the Office of Statewide Health Planning and Development (OSHPD) range from 6-12 air exchanges per hour. The local health officer, the State TB Control Branch and, OSHPD may be useful in identifying resources and evaluating options.

department on where to go for follow-up care; short-term written prescriptions; or, a small supply of medication for continuation of treatment while the inmate is arranging for medical services in the community.

Since follow-up care may be completed by another facility to which the inmate is being transferred, the follow-up plan should also discuss implementing the requirements of **HSC Sections 121361** and **121362**, which were revised in 1993 and 1994. These statutes require advance notification to the receiving facility's chief medical officer and the sending facility's local health officer when sending an individual with known or suspected active tuberculosis to another jurisdiction. Advance notification to the local health officer is necessary whenever an inmate who is known or suspected to have active (infectious) tuberculosis is transferred to another jurisdiction or released to the community. (Also referenced in the guidelines to **Sections 1205, Medical/Mental Health Records** and **1206, Health Care Procedures Manual**.)

Section 1206, Health Care Procedures Manual, specifies that a health care transfer of information form accompany all inmates upon transfer to a facility in another jurisdiction, regardless of their health status. In these instances, "another jurisdiction" means a state prison or a jail in another county. The transfer of this information among jurisdictions is becoming increasingly critical for all concerned as it reduces costs and unnecessary exposure to diseases. Transfer information should not only include current diagnoses and treatment, but should also indicate when there has been an exposure to a communicable disease for which follow-up observation and testing is needed.

This communicable disease management regulation also addresses reporting requirements that are the responsibility of the health care staff. Policies must provide a timeframe within which certain known or suspected cases are reported to the local health officer, pursuant to **Title 17, Section 2500 CCR**. This regulation does not apply to court holding, temporary holding and Type I facilities, which do not retain inmates long enough for communicable diseases to be confirmed, and therefore, reportable. Additionally, there are requirements to notify custody administrators of communicable diseases, as required by **HSC Section 121070**. **Appendix 6** provides a format for this confidential notification process. To further address this statute and related concerns, policy and procedure should specify: (1) types of communicable diseases to be reported; (2) who is responsible for reporting; (3) which persons shall receive medical reports; (4) when and how medical information will be shared with custody staff; (5) requirements for treating information confidentially; (6) procedures for housing inmates based on their medical needs as well as how their behavior affects their risk for transmitting disease to others; and (7) policy addressing requirements for obtaining inmate consent for testing for communicable diseases and describing when consent is or is not necessary for disclosure of results.

Although **Title 15** regulations apply to inmate and overall institutional safety, the facility may choose to address communicable disease issues relating to staff in the Communicable Disease Control Plan. Alternatively, these issues can be addressed elsewhere in the department's "injury and illness prevention plan." Considerations include procedures for staff to follow whenever they may have been exposed to a communicable disease. To a certain extent, required approaches related to employees are outlined specifically elsewhere, such as in OSHA's "blood-borne pathogen" regulations **[General Industry Safety Orders, Section 5193, Title 8 CCR]** (See http://www.dir.ca.gov/title8/5193.html).

1207. Medical Receiving Screening.

With the exception of inmates transferred directly within a custody system with documented receiving screening, a screening shall be completed on all inmates at the time of intake. This screening shall be completed in accordance with written procedures and shall include but not be limited to medical and mental health problems, developmental disabilities, and communicable diseases, including, but not limited to, tuberculosis and other airborne diseases. The screening shall be performed by licensed health personnel or trained facility staff.

The facility administrator and responsible physician shall develop a written plan for complying with Penal Code Section 2656 (orthopedic or prosthetic appliance used by inmates).

There shall be a written plan to provide care for any inmate who appears at this screening to be in need of or who requests medical, mental health, or developmental disability treatment.

Written procedures and screening protocol shall be established by the responsible physician in cooperation with the facility administrator.

Guideline: Receiving screening is a process of structured inquiry and observation designed to prevent newly arriving inmates who pose a health or safety threat to themselves or others from being admitted to a facility's general population. The regulation also requires providing necessary health care when indicated. Receiving screening can be performed by appropriately licensed or certified health personnel or by trained correctional staff. It is critical that it occurs when a prisoner arrives at a facility (i.e., at the time of entry to the facility). Placing two or more inmates in a holding cell pending later screening is not acceptable practice if either inmate is suspected of having a communicable disease **(Section 1051, Communicable Diseases)**. The jail must find out at the earliest possible point who is carrying a contagious disease, who is in need of medical attention and/or who should not be admitted to the jail for medical/mental health reasons. This initial receiving screening protects the jail, its inmates and staff from both contagious disease and from potential litigation. The communicable disease plan would address further evaluation and treatment needs **(Section 1206.5, Management of Communicable Diseases in a Custody Setting.**

Receiving screening must be completed on every inmate admitted to a facility, except those who are transferred within a custody system. The intent is for the screening information to accompany an inmate when he or she is transferred so the receiving facility will have the benefit of all the relevant health information when the inmate arrives. The findings of the receiving screening should be recorded on a printed form approved by the health authority. (If the medical receiving screening is automated, provision should be made during programming to accommodate needs for internal quality assurance monitoring.)

This regulation requires that a written plan be developed for any inmate who appears to need or "requests medical, mental health or developmental disability treatment." **Section 1069, Inmate Orientation**, requires that jail health care services be included in the orientation procedures. Inmates must be aware of what services are available and how to access them.

Individuals who are unconscious, semi-conscious, bleeding or otherwise obviously in need of immediate medical attention upon arrival at a facility should be referred immediately to emergency medical care. If they are sent to a community hospital, their admission or return to the jail should be based on written medical clearance. The California Department of Health Services has notified all counties about Medi-Cal eligibility and coverage for inmates and juvenile wards. In summary, Medi-Cal will reimburse community health care facilities for emergency services, outpatient care and inpatient treatment for Medi-Cal covered and/or eligible inmates and detained minors both prior to booking and after they are released from custody.[9]

The state's current definition of "released from custody" is that the individual is no longer incarcerated and includes: home detention with or without electronic monitoring; parole; released for time served; probation; or, individuals released on their own recognizance. A stay in sentence is not considered being released from custody for purposes of Medi-Cal reimbursement. Medi-Cal does not pay city and county jurisdictions for needed health care services provided by staff in local detention facilities. Local agencies may wish monitor changes in state or federal regulations in this area and review their custody acceptance and release practices in light of these policies.

For Type IV facilities that book inmates directly from the community, receiving screening must be accomplished at the time of intake. Type IV's that receive inmates only from other jails in their detention system can expect to receive, at the time of transfer, findings of the screening from the facility which booked or initially received the inmate. Thus, they do not have to repeat the screening process.

A medically licensed or certified person such as a registered nurse, physician's assistant or nurse practitioner may administer the receiving screening checklist; however, facilities may use non-medical staff. Non-medical personnel must be properly trained in the use of the screening form, symptom recognition and other observations the screener should make, documentation of observations, method of referral and any additional information that makes both the policy and the procedures for receiving screening clear.

The receiving screening checklist is best administered in a reasonably private setting to increase the chances of the inmate discussing any potential problems; however, this may not always be possible. The more information garnered through the screening, the better the likelihood that important issues will surface and can be addressed in classification, housing and medical/mental health service decisions.

A sample screening instrument is provided in **Appendix 7**. The areas included below are examples of the kinds of questions, observations and dispositions that may be considered when building a receiving screening process. This is not an exhaustive list, but it covers several issues the screening should address.

QUESTIONS

1. Are you currently under the care of a doctor for medical or psychiatric reasons?
2. Are you a client of the Regional Center (for Developmentally Disabled)?

[9] Minors held in juvenile facilities pending placement are also Medi-Cal eligible.

3. Are you taking pills or using other medications (including birth control)? If yes, what medications?
4. Do you regularly use drugs such as alcohol, heroin, methadone, uppers or downers? (The following questions can alert staff to whether the person has gone through withdrawal, or if staff should expect symptoms of DT's beginning approximately 24-36 hours after a person's last drink.)
   . How much do you drink?
   . When was your last drink?
   . Have you ever had a problem when you stopped drinking?
   . (Ask similar questions about other drugs.)

0. Have you ever attempted suicide? Are you thinking about suicide now?
0. For women--are you pregnant or have you delivered a baby in the last 12 months?
0. Have you had a cough for more than three weeks with any of the following: night sweats or unexplained weight loss?
0. Have you recently been in contact with a person who has tuberculosis, measles, chicken pox, or other contagious diseases?
0. Have you ever been treated for tuberculosis?

OBSERVATIONS

0. Does the inmate appear to be sick or injured, suggesting the need for immediate medical attention?
0. Does the inmate have a cough that cannot be explained by an acute respiratory problem?
0. Does the inmate show any unusual behavior suggesting the need for immediate medical/psychological evaluation, such as the risk of suicide or assault on staff or other inmates?
0. Does the inmate appear to be under the influence of drugs or alcohol that would require medical attention?
0. Does the inmate appear alert, awake and responsive to questions?
0. Does the detainee appear to be infested with lice or other vermin?

DISPOSITIONS

0. Refer to an appropriate health care service on an emergency basis.
0. Refer to classification for housing, with referral to an appropriate non-emergency health service at a later time.
0. House in the sheltered health care housing or negative pressure isolation cell.
0. Refer to classification for housing.

Each facility can include other questions that might be helpful in the management and appropriate treatment of inmates. It is extremely important for screening personnel to be trained to identify each inmate's suicide and/or drug or alcohol withdrawal potential. Review any history of suicidal or erratic behavior including: delusions; hallucinations; communication difficulties; impaired level of consciousness; disorganization; memory defects; depression; trauma or evidence of self-mutilation; and substance abuse **(Section 1219, Suicide Prevention Program)**.

A well-developed medical screening process can improve continuity of care for newly received inmates. It is imperative to have procedures for the timely continuation of essential prescription medications. Examples of critical medications include: antibiotics; oral contraceptives; psychotropic drugs; and medications for chronic medical conditions such as diabetes, high blood pressure, asthma, AIDS and heart failure. In some instances, even brief lapses in therapy can result in destabilization of an inmate's health condition, treatment failure or development of resistant strains of infections.

There are several variables that may impact the ability to respond appropriately to an inmate's need for medications. If the inmate does not provide accurate or creditable information at the time of screening, delays occur. Difficulties in verifying the prescription date or name and dosage of medication may also preclude the immediate continuation of treatment. Receiving screening procedures should result in evaluation of the information in a manner that permits resumption of therapy within a medically acceptable timeframe. Upon identification of a need, procedures must be implemented that take into account the clinical importance of the medication and an attempt must be made to conform to the required dosing intervals.

Discontinuation of pre-incarceration medications for arbitrary reasons or convenience of staff is not appropriate. Even though it may be reasonable for facility medical staff to change an inmate's medication regimen, such changes must be based on an individualized evaluation and be clinically justifiable. Even in cases where an inmate has been receiving inappropriate prescriptions for narcotics, tranquilizers, or other addicting drugs, abrupt discontinuation of the medication could result in a hazardous withdrawal syndrome. An individualized evaluation and plan for detoxification is necessary in those instances.

While continuity of care problems may be more evident in large detention systems that receive higher numbers of inmates, it can be equally problematic for smaller systems if they do not have safeguards in place or sufficiently trained intake staff. The problem may become more urgent if the inmate was held prior to arraignment in a Type I or temporary holding facility, where medical care was not continued prior to transfer to the county jail. Additionally, the county jail may create additional delays if it fails to review the screening done by the original holding facility and any health care summary information accompanying the transfer **(Section 1206, Health Care Procedures Manual)**.

Type II facilities that house juveniles should have procedures for obtaining information from a juvenile detainee as to whether the minor is emancipated, living with parent(s) or guardian(s), or, in a foster home. Placing this information in the health chart where it is easily accessible may be helpful in the event that consents are needed for medical services. It may prove worthwhile to call the parent, guardian or foster parent for additional health information about the juvenile and to make inquiries about the minor's immunization status. Additionally, staff must pay particular attention to signs of trauma and be aware of their responsibility for reporting all instances of suspected child abuse.

Type II facilities that house juveniles being tried as adults should consult with their county counsel when developing policies and procedures for such matters as "consent," since laws relating to juveniles may change. While a facility may not perform health appraisals/physical

examinations on all adult inmates, jails holding juveniles must have policies and procedures to assure that a health appraisal/medical examination is received from the sending facility at the time of or prior to transfer (**Title 15, Section 1123, Health Appraisals/Medical Examinations for Minors in Jails)**.

There must be a plan for allowing inmates to retain their orthopedic or prosthetic appliances while in custody, pursuant to **Penal Code Section 2656**. The law is very specific; it says if the facility manager:

> "…has probable cause to believe possession of such orthopedic or prosthetic appliance constitutes an immediate risk of bodily harm to any person in the facility or threatens the security of the facility, such appliance may be removed.
>
> If such appliance is removed, the prisoner shall be deprived of such appliance only during such time as the facts which constitute probable cause for its removal continue to exist; if such facts cease to exist, then the person in charge of the facility shall return such appliance to the prisoner.
>
> When such appliance is removed, the prisoner shall be examined by a physician within 24 hours after such removal."

Jails cannot deprive inmates of these devices without a legitimate security reason. Policy and procedures should discuss the security parameters that might constitute cause for withholding such an appliance, for how long and with what recourse. How artificial limbs and other prostheses are to be accommodated in the jail setting should also be addressed.

Consistent with **Section 1202, Health Service Audits,** local detention systems need to have internal auditing procedures designed to give early warning when policies, procedures and operations are breaking down. It is critical to include issues related to receiving screening and treatment continuity in this system. Inmate grievances that outline valid continuity of care issues should also be reviewed in detail, as they can provide valuable information concerning where delivery systems fail.

Other regulations that may be helpful when developing procedures for receiving screening and orthopedic and prosthetic appliances include: **Section 1050, Classification Plan; Section 1206, Health Care Procedures Manual; Section 1206.5, Management of Communicable Diseases in a Custody Setting; Section 1207.5, Special Mental Disorder Assessment; Section 1208, Access to Treatment; Section 1209, Mental Health Services and Transfer to Treatment Facility**; and **Section 1210, Individualized Treatment Plans**.

1207.5. Special Mental Disorder Assessment.

An additional mental health screening will be performed, according to written procedures, on women who have given birth within the past year and are charged with murder or attempted murder of their infants. Such screening will be performed at intake and if the assessment indicates postpartum psychosis a referral for further evaluation will be made.

Guideline: The purpose of this regulation is to help identify those women who are suffering from postpartum depression that may cause them to be a danger to themselves or others. As noted in the guidelines to **Section 1207, Medical Receiving Screening** , the medical receiving screening instrument should ask women if they have given birth within the last year. Those who respond positively, have been charged with murder or attempted murder of their babies, and are being screened at a temporary holding or Type I facility, should be immediately transferred to a Type II facility for the evaluation called for by this regulation. Written policy should specify that this transfer occur.

1208. Access to Treatment.

The health authority, in cooperation with the facility administrator, shall develop a written plan for identifying, assessing, treating and/or referring any inmate who appears to be in need of medical, mental health or developmental disability treatment at any time during his/her incarceration subsequent to the receiving screening. This evaluation shall be performed by licensed health personnel.

Guideline: Access to treatment is an important element of **the Health Care Procedures Manual** required by **Section 1206** and is related to the **Medical Receiving Screening** called for by **Section 1207**.

Policies and procedures related to treatment access should include, at a minimum:

- a written procedure for 24-hour emergency access to medical, dental and mental health services personnel;
- a written plan for non-emergency access to medical, dental and mental health services which permits inmates to refer themselves for preliminary evaluation and ensures that the inmates will be seen by a member of the health staff within a reasonable period of time;
- a written procedure for timely referral by custody and/or health staff to mental health services for those inmates who exhibit signs of mental or emotional disorder and inmates who request evaluation;
- a written method by which family or advocates for inmates may make requests for preliminary psychiatric evaluations, for medical attention or for evaluation by the Regional Center for Developmental Disabilities;
- a written procedure for transportation or escort to ensure inmate access to health services; and,
- a written procedure for ensuring access to health care specialists including a description of the referral, transportation, treatment and follow-up processes.

The facility will also want to describe how inmates will be informed about availability of health care services, how to access them and how those services will be delivered. In addition to being part of inmate orientation **(Section 1069, Inmate Orientation)**, information about access to health care services should be provided to inmates in writing and be posted in heavily used areas like dayrooms and living areas.

Not all inmates will be able to read, and not all who can read will understand English. Additionally, persons with certain disabilities require that facilities make provisions for conveying this information orally, either by staff, by translator, by videotape or in some other fashion that gets the information to the inmate in a way which ensures he or she can understand and make use of it. **Section 1057, Developmentally Disabled Inmates**, provides additional information regarding screening and follow-up requirements for those inmates.

The requirement to provide access to treatment is a consideration when evaluating transport staffing and procedures. Designated health care staff may determine that follow-up is required outside the facility and these appointments need to be kept. Regularly cancelled appointments due to insufficient transport staff, can rise to the level of impeding access to treatment and its inherent legal liability.

1209. Mental Health Services and Transfer to Treatment Facility.

( ) The health authority, in cooperation with the mental health director and facility administrator, shall establish policies and procedures to provide mental health services. These services shall include but not be limited to:

0. screening for mental health problems;
0. crisis intervention and management of acute psychiatric episodes;
0. stabilization and treatment of mental disorders; and,
0. medication support services.

( ) A mentally disordered inmate who appears to be a danger to himself or others, or to be gravely disabled, shall be transferred for further evaluation to a designated Lanterman Petris Short treatment facility designated by the county and approved by the State Department of Mental Health for diagnosis and treatment of such apparent mental disorder pursuant to Penal Code section 4011.6 or 4011.8 unless the jail contains a designated treatment facility. Prior to the transfer, the inmate may be evaluated by licensed health personnel to determine if treatment can be initiated at the correctional facility. Licensed health personnel may perform an onsite assessment to determine if the inmate meets the criteria for admission to an inpatient facility, or if treatment can be initiated in the correctional facility.

Guideline: This regulation emphasizes the importance of having the scope of mental health services defined. Jails or jail systems may not always have the same provider for mental health services as they have for medical services, so the mental health director is specifically identified to work in cooperation with the health authority and the facility administrator to develop these policies and procedures. **Section 1006, Definitions,** identifies the mental health director as "that individual who is designated by contract, written agreement or job description, to have administrative responsibility for the facility or system mental health program." This is not necessarily the county mental health director. The regulation specifies four areas of mental health services that must be provided and addressed in policy:

0. screening for mental health problems;
0. crisis intervention and management of acute psychiatric episodes;
0. stabilization and treatment of mental disorders; and,
0. medication support services.

Most local detention facilities are not equipped or staffed to confine people who are severely mentally disordered. Jails are not generally designated Lanterman Petris Short (LPS) treatment facilities. **Penal Code Section 4011.6** allows involuntary transfer of any detainee or inmate who fits the clinical criteria set forth in **W & I Code Section 5150**. **Penal Code Section 4011.8** allows for the voluntary transfer of any detainee or inmate who appears to be a danger to himself or others or is gravely disabled. People who are "gravely disabled" are those who lack the ability to provide food, clothing and shelter for themselves and, in the jail context, lack the ability to utilize those items as provided. In cases where inmates agree to treatment on a voluntary basis, the transfer would generally occur under **Penal Code Section 4011.8**. It is important to note that inmates cannot simply demand transfer to a mental health facility for voluntary treatment. Such transfers are subject to approval of the judge or person in charge of the jail as well as the local mental health director in the county where the services would be rendered.

While **Penal Code Section 4011.6** allows any facility administrator, manager or judge of the county to implement such a transfer, it is ideally done after evaluation by or consultation with mental health staff designated by the health authority or county mental health director. The regulation allows a system to establish procedures for off-site licensed health personnel to come to the jail to interview an inmate to determine whether he or she meets the **W & I Code 5150** criteria for involuntary inpatient care or whether treatment at the facility may be a more appropriate option. Referrals of inmates for mental health evaluations are often based upon abnormal behavior that suggests the possibility of mental illness **(Section 1052, Mentally Disordered Inmates)**. A preliminary evaluation will help sort out those inmates who are amenable to psychiatric treatment versus those whose behavior is expected to be self-limiting (e.g., drug intoxication) or based on factors for which treatment efforts are futile (e.g., personality disorders). Given the shortage of available treatment facilities, jail personnel can expect that transfers to treatment facilities may not be easily accomplished and are often less than timely, regardless of how necessary the transfer may be.

For liability purposes, it is important that all efforts to transfer mentally disordered persons are documented. In addition to conducting a mental health evaluation of the individual inmate, mental health staff must also be cognizant of the jail's population, conditions, regulations and resources in order to make the most reasonable judgment as to who should be transferred out of the jail for treatment and who can be retained.

Transferring or retaining these individuals in jail is often a difficult and controversial decision since there are some clearly disturbed and problematic people for whom neither jail nor acute care hospitals seem appropriate. They will be extremely difficult to manage in either setting. Policies and procedures should address how such decisions are made, and should stress the importance of communication and coordination among health, judicial and custody personnel in this regard. Transfer to a treatment facility will be influenced in large part by what other facilities exist in the city or county and by the condition and legal status of the inmate.

The facility administrator and the health authority should jointly develop the policies and procedures, and ensure that the necessary forms and contact persons authorized to accomplish transfers are included in the manual. For ease of access, the names and telephone numbers of

key judges, probation officers, treatment facility contacts, and transportation units should be identified in a location where they are easily accessible.

The importance of documentation and maintaining records pertaining to the handling of a mentally disordered person cannot be overemphasized. There should be a policy that all telephone contacts be documented and these records or logs, along with all others, must be scrupulously maintained.

Dealing with seriously mentally disordered inmates is an increasingly acute problem for facility administrators, as community resources disappear. The experience in many communities is that there are no suitable facilities to which inmates can be transferred, forcing decisions to enhance the quality of services provided in local detention facilities. Facility administrators are being asked to expand the mental health services available in jails even though the Board of Corrections, mental health personnel and facility administrators across the state agree that it is best to get seriously mentally disordered people out of jails. Administrators must work cooperatively with mental health officials and others in the community to improve mental health services outside the jail in lieu of using the jail as the mental health service provider of last resort.

The shortage of inpatient psychiatric facilities has led some counties to create jail inpatient psychiatric units to provide acute inpatient services for inmates referred under **Penal Code Sections 4011.6 and 4011.8**. Development of such a unit requires a close working relationship between custody and mental health staff. In addition to the usual issues of security and safety, these units will have special security and safety requirements because of the unique needs of the inmates. If treatment of acutely and seriously disordered persons is undertaken in a jail, it is critically important that the treatment area be formally specified by the local mental health director and Board of Supervisors as a "designated" facility, and to assure that all applicable requirements for operating such a unit are met. This is particularly important when administration of medication on an involuntary basis is considered, as there are legally defined constraints that must be addressed. Jails that attempt to provide inpatient psychiatric care without complying with all laws and regulations that are applicable in the community, do so at great peril, both with respect to the safety of the patient and liability of the facility.

Effective January 1996, units which provide levels of health care parallel to licensed community facilities are required to have a Correctional Treatment Center licensure under **Title 22 CCR** or be a "designated facility" treatment facility and met the requirements of **Title 9, CCR.**

1210. Individualized Treatment Plans.

(a) For each inmate treated by a mental health service in a jail, the treatment staff shall develop a written treatment plan. The custody staff shall be informed of the treatment plan when necessary, to ensure coordination and cooperation in the ongoing care of the inmate. This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.

(b) For each inmate treated for a major medical problem in a jail, the treatment staff shall develop a written treatment plan. The custody staff shall be informed of the treatment plan when necessary, to ensure coordination and cooperation in the

ongoing care of the inmate. This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.

Guideline: For the purpose of this section, treatment plans are an outline of anticipated health care requirements during the period of incarceration for inmates with special needs. The regulation applies to inmates with either medical or mental health disorders, as well as some disabling conditions (e.g., certain physical disabilities). The complexity of the plan should reflect the extent of the individual's needs. The goal is to assure that the inmate's health does not undergo preventable deterioration during incarceration. In some situations, a progress note in the medical record will suffice. In others, a more formalized approach is appropriate. The intent is to assure that the inmate's health needs are systematically addressed. To be effective, the plan must be clearly stated and easily accessible to treatment staff. This regulation primarily applies to the outpatient setting and does not mitigate the importance of complying with additional requirements for more extensive treatment plans in other situations, such as in certain psychiatric treatment programs.

Penal Code Section 4011 details the legal procedure for transferring seriously ill or injured inmates to a hospital for extended treatment and also preserves inmate rights to decline health services and request care through a private physician at their own expense.

Both custody and health care staff will maintain confidential records that are distinct to their own operations **(Section 1041, Inmate Records** and **Section 1205, Medical/Mental Health Records)**. A medical or mental health treatment plan developed for an individual being treated in the jail will often include topics within the purview of the custody staff, such as classification and cell assignment for that inmate. Without violating the confidentiality of the clinical record, it is both reasonable and necessary for mental health staff to share the basic reasoning and conclusion of their housing, classification or monitoring recommendations. Important information must be shared and transmitted among medical, mental health and custody personnel for optimum functioning of the health system and the jail. Such information must be handled professionally and remain confidential within the group.

Mental health staff must inform custody personnel when an inmate is suicidal, homicidal or inappropriately housed in the jail for health care reasons. With appropriate training, medical staff may, in some circumstances, act as back up to mental health staff. Medical and mental health personnel should work as a team with custody personnel.

Special housing is often the preferred arrangement for inmates who need close observation due to mental or emotional disorders and for those being evaluated for these disorders. Please see **Section 1052, Mentally Disordered Inmates,** for discussion of mentally disordered inmates and note that safety cells (**Section 1055, Use of Safety Cell**) cannot be considered special housing for purposes of treatment.

There should be specific written criteria and procedures for admission to and discharge from a special mental health housing area. Mental health staff recommendations are critical regarding individual placement within these special housing units. Every inmate placed in special housing and all inmates for whom medication for mental or emotional disorders are prescribed, need to have an individualized written treatment plan based on the evaluation by the mental health staff.

A treatment plan for developmentally disabled inmates may be appropriate, although this is not a specific requirement of this regulation. If a developmentally disabled inmate is a Regional Center client, there is an established individual program plan to assist the person in maintaining and improving his or her skill level **(Section 1057**, **Developmentally Disabled Inmates** and **Section 1206**, **Health Care Procedures Manual)**. Maintaining close contact with the Center will enable the inmate to continue under that plan and can assist health care staff in the jail to follow through with the Regional Center plan.

Individualized treatment plans should address not only a plan of care during incarceration, but should also anticipate what is needed to facilitate a smooth transition back into the community after release. The process of making specific arrangements in advance of a scheduled release date might be termed "pre-release planning." Possible considerations include provision for continuation of medications, special medical equipment, follow-up appointments, and even housing needs. Although it is not always possible or practical to accomplish this type of planning, it is in the overall interest of both the inmate and the community to prevent unnecessary lapses in treatment after release. A related form of pre-release planning might include the provision of required health clearances for inmates being released to residential drug treatment programs.

Attention to continuity of care and release planning has been heightened by the 1999 **Wakefield v Thompson** decision which included requirements that the State Department of Corrections provide necessary medications upon release. This is an evolving issue and administrators should stay current with any subsequent legislation and litigation in this area and give consideration to continuity of care and availability of medication upon release when developing their policies and procedures.

Treatment planning, especially prior to release, is a multi-disciplinary activity and is likely to involve public health and social services. Examples include: the need to place newborns of pregnant women who give birth while in custody; placement of inmates who are under conservatorship; and follow-up of persons under treatment for tuberculosis. In the latter case, the local health department must be notified prior to releasing an inmate with known or suspected active tuberculosis under **HSC Sections 121361 and 121362.** The responsibility for developing treatment and pre-release plans resides primarily with health staff. However, in addition to working cooperatively with treatment staff to implement the plan, it is valuable for custody staff to share any information that may be relevant to the process.

1211. Sick Call.

There shall be written policies and procedures developed by the facility administrator, in cooperation with the health authority, which provides for a daily sick call conducted for all inmates or provision made that any inmate requesting medical/mental health attention be given such attention.

Guideline: Sick call is an opportunity for inmates to voice health concerns and be treated or referred for treatment. It is often considered synonymous with a clinic visit, but for systems without daily on-site health care staff, sick call may be only a system for receiving requests and

making referrals. For sick call to be effective, each inmate must be able to report health conditions and receive appropriate medical/mental health services for non-emergency illness or injury. Sick call is the means through which health care staff can identify, examine and/or care for inmate illnesses or injuries or make appropriate referrals for special health attention.

Every facility operates sick call a little differently depending on size, design and staffing patterns. It is crucial that the way in which sick call operates is documented in detailed policies and procedures to ensure that inmate health care needs are appropriately met. The guiding principle should be that any inmate requesting medical/mental health attention must receive that attention as soon as is reasonable and possible.

A daily sick call time and place should be established and inmates should be informed of the process during inmate orientation **(Section 1069, Inmate Orientation).** Signs should be posted conspicuously in dayrooms and living units. Special provision must be made for those who are unable to read, for non-English speaking inmates, and for persons with certain disabilities to understand this information.

Facilities that do not have health care personnel onsite may want to develop policies and procedures for custody staff to collect health care requests, and refer them to appropriate health care providers each day. Policy may allow custody personnel who conduct sick call to handle minor problems as defined by the responsible physician, but notify a doctor or other health professional as needed for more serious matters. Custody staff may also take inmates to health services or arrange for medical professionals to come into the facility.

When conducted by custody personnel, the intent of sick call is not to decide who needs medical attention, but to appropriately refer everyone making a request for health care. Sometimes custody staff has to make a judgment about the urgency of referral, but they must be careful to avoid making diagnosis decisions about the inmate's condition. It is up to health personnel to determine the kind of attention an inmate requires. Inmate requests at sick call need not be construed to mandate any level of care or type of service, but instead can be viewed as a means of getting the attention of health care personnel who will then determine what intervention best fits the situation.

If an inmate misses a regularly scheduled sick call, but requests health care attention, it is important that there be a way to refer that individual to health services as soon as possible.

In Type IV facilities, the plan for sick call may be to refer inmates to medical services provided in the community. As described in guidelines for **Section 1200, Responsibility for Health Care Services,** providing access into the community is in compliance with this regulation. Facilities that follow this practice must have a written plan that describes this process.

1212. Vermin Control.

The responsible physician shall develop a written plan for the control and treatment of vermin-infested inmates. There shall be written, medical protocols, signed by the responsible physician, for the treatment of persons suspected of being infested or having contact with a vermin-infested inmate.

Guideline: Vermin control is addressed in three regulations because there are several components to maintaining a clean and sanitary facility. This regulation is specific to the management of vermin infested inmates. In general, most infections are the result of a recently admitted inmate who is vermin infested. While the written plan developed by the responsible physician will include medical protocols for treating inmate clothing, personal effects and living areas, particular attention must be paid to treating the infested inmate. **Section 1264, Control of Vermin on Inmates' Personal Clothing** addresses control of vermin in clothing and **Section 1280, Facility Sanitation, Safety and Maintenance,** speaks to facility sanitation.

Inmates with lice or mites must be treated as soon as the infestation is identified to avoid spreading vermin. Nonetheless, treatment is recommended only when an infestation exists. Facilities should not routinely treat all incoming inmates, as allergic reactions and other negative effects can occur from treatment.

"Pediculosis" is the name of the condition in which a person is infested with one or more species of lice; the species occurring on people are body lice, head lice and pubic (or crab) lice. Body lice and their eggs (or nits) are usually found in the seams of clothing although some nits may be glued to the body hair. The application of pediculicides is directed toward killing these nits and lice that are on the body and eliminating lice on clothing. If the infested inmate's clothing and other belongings are properly bagged, labeled and immediately removed from the facility, no disinfecting is required. Removal is the safest option and eliminates the possibility of the facility being sued for clothing damage resulting from disinfecting. When the infested clothing and other belongings are retained by the facility, lice and their eggs may be killed by:

0. washing in water at 140 degrees F for 20 minutes;
0. tumbling in a clothes dryer at 140 degrees F for 20 minutes;
0. dry cleaning;
0. storing in sealed plastic bags for 30 days; and/or,
0. treating with an insecticide specifically labeled for this purpose.

Head lice and their eggs are generally found on the head hairs. There is some uncertainty about the effectiveness of some available pediculicides to kill the eggs of head lice; therefore, some products recommend a second treatment seven to ten days after the first. During the interim, before the second application, eggs of head lice could hatch and there is a possibility that lice could be transmitted to others; however, the risk is not great. Separate quarters for inmates undergoing treatment for head lice would further reduce the chances of transmission.

Pubic lice and their eggs are generally found on the hairs of the pubic area and adjacent hairy parts of the body, although they can occur on almost any hairy part of the body, including the hair under the arm and eyelashes. Pubic lice and their eggs are generally successfully treated by

the available pediculicides; however, when the eyelashes are infested with pubic lice and their eggs, a physician should carry out the treatment.

It is important to distinguish between sprays intended for use only on furniture and clothing and products allowed for use on humans. Successful treatment depends on careful inspection of the inmate and proper application of the appropriate product. The area used to delouse inmates needs to be separate from the rest of the jail. Be sure that the surfaces in this area are easily cleanable and can be sanitized. There must be a shower as part of the delousing area.

1213. Detoxification Treatment.

The responsible physician shall develop written medical policies on detoxification which shall include a statement as to whether detoxification will be provided within the facility or require transfer to a licensed medical facility. The facility detoxification protocol shall include procedures and symptoms necessitating immediate transfer to a hospital or other medical facility.

Facilities without medically licensed personnel in attendance shall not retain inmates undergoing withdrawal reactions judged or defined in policy, by the responsible physician, as not being readily controllable with available medical treatment. Such facilities shall arrange for immediate transfer to an appropriate medical facility.

Guideline: Detoxification has different meanings for medical professionals and lay people. Lay people often understand it to be a sobering up process, while medical professionals emphasize detoxification as a serious medical condition. This regulation addresses the entire process with particular attention to withdrawal as a medical problem. For the purposes of this guideline, consider "detoxification" the medical process for long-term treatment, while "sobering up" or "drying out" is the shorter-term activity, both of which occur in jails.

Under these circumstances, the sobering cell **(Section 1056, Sobering Cell)** is essentially the initial sheltered environment in which inmates can sober up. It is not a place where inmates should be held if they have life threatening withdrawal symptoms. Nor is it the place for long-term detoxification. Inmates undergoing detoxification and exhibiting signs of withdrawal should be placed in medical or general housing areas that have the ability to provide proper medical attention and monitoring.

Jail protocols must distinguish between those who only need to sober up and those who have or are experiencing withdrawal symptoms. Additionally, the protocols must tell staff when people are too intoxicated or medically fragile to be admitted to the detention facility at all and should be referred immediately to a medical facility. This is a particularly critical issue for facilities without on-site medical staff.

The health authority is responsible for developing detoxification protocols for the diagnosis and treatment of the various kinds of drug withdrawals commonly seen in local detention facilities. The most common withdrawal reactions are from alcohol, opiates, amphetamines, benzodiazepines and barbiturates. The specific protocols for their diagnosis and treatment must be written and/or approved by the responsible physician and carried out by properly trained,

medically licensed staff **(Sections 1200, Responsibility for Health Care Services** and **1203, Health Care Staff Qualifications)**.

Additionally, custody personnel should be trained to recognize inmates undergoing drug or alcohol withdrawal and to implement the written procedure for immediate referral to medical care. In each specific detoxification protocol, the signs and symptoms of serious and/or life threatening reactions requiring hospitalization should be identified, for example:

- alcohol – delirium tremens with fever, tachycardia, tremor, hallucinations and/or shock;
- benzodiazepine (minor tranquilizers) – similar to alcohol but delayed in onset;
- barbiturates – severe agitation, fever, seizures and/or shock;
- amphetamines (including cocaine) – severe agitation, hypertension, fever, seizures and/or shock; and,
- PCP (phencyclidine) – severe agitation, violent behavior, severe hypertension, fever, seizure and/or shock.

In the case of amphetamines and PCP, the life threatening stage is during intoxication. Opiate withdrawal rarely requires hospitalization. There have been incidents where dehydration, along with underlying medical conditions has resulted in an inmate death. Care should be taken to verify medical histories and monitor fluids. Lastly, opiate addicted inmates that are pregnant require particularly close monitoring. Synthetically developed designer drugs are particularly unpredictable in their impact, so protocols should include procedures for observing, handling, treating and monitoring these inmates.

HSC Sections 11222 and 11877 require that inmates who are enrolled in a licensed community methadone maintenance program be allowed to continue that program until conviction. This continuation is at the discretion of the community program director. Either jails need to have effective relationships with the community program to deliver the methadone in jail, or the jail program needs to have the ability to administer methadone. The rules governing the distribution of methadone and other medications to treat addiction have undergone significant changes in recent years. Medical providers should work with their local substance abuse agency to determine the most recent rules for treatment or contact the State Department of Alcohol and Drug Programs. See (www.adp.cahwnet.gov) for further information.

As outlined in **Section 1056**, **Use of the Sobering Cell**, inmates who are a threat to their own safety or the safety of others due to their state of intoxication must be placed in the sobering cell if they are retained in the facility. The inmate must be conscious, able to respond to simple commands, have no difficulty breathing and not appear acutely ill to be held in a sobering cell. All inmates in these cells must be checked at least every half hour, or more frequently as necessary, for signs of deterioration of their medical condition; i.e., are they less easily aroused? Is there decreasing ability to follow simple commands? Are they having difficulty breathing? Do they appear acutely ill? Monitoring of inmates in sobering cells must be documented in the same manner as is used for inmates in safety cells **(Section 1055, Use of Safety Cell)**, with actual time of the check recorded. If the inmate's condition deteriorates, the written plan for immediate medical evaluation must be followed. Please refer to the **Guidelines for Title 15,**

Program and Procedures Standards for a detailed discussion of requirements for managing sobering cells.

1214. Informed Consent.

The health authority shall set forth in writing a plan for informed consent of inmates in a language understood by the inmate. Except for emergency treatment, as defined in Business and Professions Code Section 2397 and Title 15, Section 1217, all examinations, treatments and procedures affected by informed consent standards in the community are likewise observed for inmate care. In the case of minors, or conservatees, the informed consent of parent, guardian or legal custodian applies where required by law. Any inmate who has not been adjudicated to be incompetent may refuse non-emergency medical and mental health care. Absent informed consent in non-emergency situations, a court order is required before involuntary medical treatment can be administered to an inmate.

Guideline: Informed consent is the process for ensuring that the nature, consequences, risks and alternatives concerning a proposed treatment are understood and agreed to by the person who is to receive the health service. Informed consent is obtained for all voluntary medical and mental health examinations, treatments and procedures, and is obtained by health personnel rather than custody staff.

The regulation states that informed consent must be accomplished in a language understood by the inmate. That means facilities must consider both language (i.e., English, Spanish, Hmong, etc.) and vocabulary that the inmate can understand. Additionally, it is the intent of the regulation that facilities have a means to communicate consent requirements to inmates who have disabilities such as hearing and visual impairments. Some inmates, for example those with severe learning disabilities or mental disorders, may not be able to understand and/or give informed consent. It is important to remember that treatment cannot proceed without consent from the individual, or consent provided by a legal guardian or conservator (if authorized by the court to give consent for medical care). Absent this consent, a court order must be obtained, except in an emergency. Consent is generally required for invasive medical procedures, including minor surgery and endoscopic examinations. Although verbal consent is acceptable for many types of routine care, local community practice should serve as a guide to whether or not signed consent is warranted. When in doubt, it is better to obtain written consent.

Consent for care should reflect the usual and customary practices in the free community, with the exception of Telemedicine. Business and Professions Code 2290.5 (j) removes the requirements for both written and verbal consent if the patient is under the jurisdiction of a correctional facility.

Informed consent requirements apply to all forms of health care, including medical, dental, and mental health. While the elements of informed consent are similar in all health professions, it is specifically defined for mental health facilities **in W & I Code, Section 5326.2**. Those requirements follow:

To constitute voluntary informed consent, the following information shall be given to the patient in a clear and explicit manner:

1. The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.
0. The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.
0. The probable degree and duration (temporary or permanent) of improvement or remission expected, with or without such treatment.
0. The nature, degree, duration, and the probability of side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.
0. That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and its commonly known risks and side effects.
0. The reasonable alternative treatments, and why the physician is recommending this particular treatment.
0. That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.

Informed consent must be obtained when an inmate is voluntarily admitted for inpatient mental health treatment. When an inmate is detained on an involuntary basis for mental health evaluation, it is necessary to obtain consent before administering psychotropic medications. In those instances where an inmate refuses to comply with a recommendation to take psychotropic medications under non-emergency circumstances, there must be a determination that the inmate lacks the capacity to give informed consent. The determination of capacity for decision-making requires a formal hearing process **(Section 1217, Psychotropic Medications)**. It is important to remember that the decision to proceed with the involuntary administration of psychotropic medications in a non-emergency situation cannot be made as a bedside clinical diagnosis.

Informed consent is not required in an emergency. This is true for both medical and psychiatric emergencies; however, emergencies are defined in statute. That definition of "emergency medical situations" is reiterated in **Section 1006, Definitions** of these regulations and states that these emergencies are "…those situations where immediate services are required for the alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed and treated." Similarly, a mental health emergency is defined in **Section 1217, Psychotropic Medications** to be "a situation in which action to impose treatment over an inmate's objections is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impractical to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment." These definitions should be strictly adhered to when proceeding with treatment over an inmate's objections, or in the absence of the inmate's ability to give consent.

Non-emergency treatment of medical conditions (regardless of whether or not the inmate is receiving psychiatric care) in the absence of consent by the patient or a legally authorized

representative, requires a court order. Not all court-appointed conservators are granted the authority to consent to medical treatment for their conservatees. This means that even if a patient has been judged to lack capacity for consent to psychotropic medications and is receiving them on an involuntary basis, additional treatment for other medical conditions would require a court order if the patient were unable or unwilling to provide consent. In non-emergency situations, a patient may refuse both medical and mental health treatment. This can be done either verbally or in writing. Although written refusal of treatment affords some degree of liability protections to the health provider, it is not essential. A patient who has previously consented to care can withdraw that consent at any time.

An evolving debate for detention facilities relates to "advance directives" for medical care. These are documents, sometimes referred to as "living wills," which allow a person to define the direction and desired limitations of medical care in advance of any situation in which they might be rendered unable to speak for themselves. Some individuals may appoint a "durable power of attorney" in which they name an individual to act on their behalf with respect to decision-making under such circumstances. When executed properly, these documents are legally recognized and should be taken into account when treating patients who are no longer capable of participating in deciding their course of treatment. This may apply to both chronic and end-of-life care.

Although the concept of advance directives is relatively straightforward, the custody setting poses special dilemmas with respect to their implementation. Concerns may be raised as to whether an inmate's state of mind is being influenced by the fact of incarceration. For this reason, advance directives created *prior to* incarceration may be less likely to reflect temporary negative factors influencing the judgment of the individual. For jail administrators, there are concerns over how to manage and report in-custody deaths that have been allowed to take a natural course. Additional questions arise about whether or not interventions should be made in the case of assault-related injuries or a suicide attempt involving an inmate who has requested non-intervention for a terminal medical condition. On the other hand, it is clearly established medical principle that health providers cannot render unwanted treatment. While it is clear that further discussion about the ethical and legal aspects of advance directives is needed, local jurisdictions should begin to scrutinize their own policies and consult with legal counsel to address this issue to the best of their ability.

1215. Dental Care.

The facility administrator shall develop written policies and procedures to ensure emergency and medically required dental care is provided to each inmate, upon request, under the direction and supervision of a dentist, licensed in the state.

Guideline: The facility administrator should consult with the health authority to identify the level of dental services available to inmates and the steps to be taken in cases of dental emergencies. The approach to dental emergencies needs to be expressed in clear,, simple procedures so custody and health staff know exactly whom to summon, what transportation is required, and what temporary measures are to be taken until a dentist is available.

Medically required dental care is that arising from a dental condition which interferes with the general health of the inmate. While health care and custody personnel are not expected to

determine whether or not an inmate needs dental care, both have the responsibility to make appropriate referrals to dental services. Dental care is not limited to extractions, but jail dental care is not intended to correct years of personal dental neglect; it may be limited to only that care necessary for the immediate welfare of the inmate. Policies and procedures should include responding to conditions that arise from dental injuries sustained while in custody.

If services are provided in the facility, the health authority is responsible for assuring that the proper licensing requirements are met and that appropriate supervision and coordination is available **(Sections 1203, Health Care Staff Qualifications** and **1204, Health Care Staff Procedure)**. When dental services are provided away from the facility, arrangements are needed for timely transportation to and from the place where services are to be provided.

Typically jails have a contractual or employee relationship with dental professionals, as with other health care providers. The local dental society may provide information about dental professionals who might be willing to see inmates on an emergency basis. Counties with few dentists and no dental society may want to contact the California Dental Association in Sacramento for information regarding dental care for inmates.

1216. Pharmaceutical Management.

(a) **The health authority in consultation with a pharmacist and the facility administrator, shall develop written plans, establish procedures, and provide space and accessories for the secure storage, the controlled administration, and disposal of all legally obtained drugs. Such plans, procedures, space and accessories shall include, but not be limited to, the following:**
  (1) **securely lockable cabinets, closets, and refrigeration units;**
  (2) **a means for the positive identification of the recipient of the prescribed medication;**
  (3) **procedures for administration/delivery of medicines to inmates as prescribed;**
  (4) **confirming that the recipient has ingested the medication or accounting for medication under self-administration procedures outlined in Section 1216(d);**
  (5) **that prescribed medications have or have not been administered, by whom, and if not, for what reason;**
  (6) **prohibiting the delivery of drugs by inmates;**
  (7) **limitation to the length of time medication may be administered without further medical evaluation; and,**
  (8) **limitation to the length of time required for a physician's signature on verbal orders.**
  (9) **A written report shall be prepared by a pharmacist, no less than annually, on the status of pharmacy services in the institution. The pharmacist shall provide the report to the health authority and the facility administrator.**

(a) **Consistent with pharmacy laws and regulations, the health authority shall establish written protocols that limit the following functions to being performed by the identified personnel:**
  (1) **Procurement shall be done by a physician, dentist, pharmacist, or other persons authorized by law.**

(2) **Storage of medications shall assure that stock supplies of legend medications shall be accessed only by licensed health personnel. Supplies of legend medications that have been dispensed and supplies of over-the-counter medications may be accessed by either licensed or non-licensed personnel.**

(3) **Repackaging shall only be done by a physician, dentist, pharmacist, or other persons authorized by law.**

(4) **Preparation of labels can only be done by a physician, dentist, pharmacist or other persons, either licensed or non-licensed, provided the label is checked and affixed to the medication container by the physician, dentist, or pharmacist before administration or delivery to the inmate. Labels shall be prepared in accordance with section 4076, Business and Professions Code.**

(5) **Dispensing shall only be done by a physician, dentist, pharmacist, or persons authorized by law.**

(6) **Administration of medication shall only be done by licensed health personnel who are authorized to administer medication acting on the order of a prescriber.**

(7) **Delivery of medication may be done by either licensed or non-licensed personnel, e.g., custody staff, acting on the order of a prescriber.**

(8) **Disposal of legend medication shall be done in accordance with pharmacy laws and regulations and requires any combination of two of the following classifications: physician, dentist, pharmacist, or registered nurse. Controlled substances shall be disposed of in accordance with the Drug Enforcement Administration disposal procedures.**

(a) **Policy and procedures on "over-the-counter" medications shall include, but not be limited to, how they are made available, documentation when delivered by staff and precautions against hoarding large quantities.**

(a) Policy and procedures may allow inmate self-administration of prescribed medications under limited circumstances. Policies and procedures shall include but are not limited to the following considerations:

(1) Medications permitted for self-administration are limited to those with no recognized abuse potential. Medications for treatment of tuberculosis, psychotropic medication, controlled substances, injectables and any medications for which documentation of ingestion is essential are excluded from self-administration.

(2) Inmates with histories of frequent rule violations of any type, or who are found to be in violation of rules regarding self-administration, are excluded from self-administration.

(3) Prescribing health care staff document that each inmate participating in self-administration is capable of understanding and following the rules of the program and instructions for medication use.

(4) Provisions are made for the secure storage of the prescribed medication when it is not on the inmate's person.

(5) Provisions are made for the consistent enforcement of self-medication rules by both custody and health care staff, with systems of communication among them when either one finds that an inmate is in violation of rules regarding self-administration.

(6) Provisions are made for health care staff to perform documented assessments of inmate compliance with self-administration medication regimens. Compliance evaluations are done with sufficient frequency to guard against hoarding medication and deterioration of the inmate's health.

Guideline: **Section 1006, Definitions**, identifies key terms related to this regulation and to the pharmaceutical management of legally obtained drugs.

This regulation distinguishes between prescription drugs and over-the-counter (OTC) medications. As with most other regulations, it calls for policies and procedures, in this instance, developed by the health administrator in consultation with the facility administrator and a pharmacist.

The issues related to legally obtained drugs are complex and pose the potential for significant liability. It is important to describe how prescription and other medications are securely stored and administered or delivered as well as outline specific disposal methods. Each facility should have procedures that assure compliance with all applicable state and federal laws and regulations regarding: acquisition; storage; labeling; packaging; disposal; and administration of drugs. Despite the uniqueness of the jail environment, the same laws and regulations as in the community govern all aspects of health care services, including the management of pharmaceuticals.

To assure that both prescription and nonprescription drugs are managed properly in the jail setting, it is advisable to hire a pharmacist consultant; in large jails, it may be cost effective to hire an on-site pharmacist. The pharmacist or consultant can work in conjunction with the health authority to: make recommendations regarding the facility formulary; assure appropriate storage, handling and inventory control; provide for destruction of old medication; conduct regular chart reviews on medication utilization; and participate on various committees.

With regard to **Subsection (a)(1)**, it is important that all medical supplies be kept in a secure area of the facility with access limited by proper key control. A close inventory must be kept of these supplies to ensure that unauthorized use or removal will be promptly discovered. While all medications must be maintained in secure locations and under appropriate conditions to assure their effectiveness, legend drugs must be kept in securely locked cabinets. Access to medications must be limited by policy. In larger jurisdictions with designated pharmacies, the facility manager may have a key to the pharmacy or drug area for security reasons, but not to the controlled substance storage area.

In order for stocks of controlled substances to be maintained in a facility, the facility must be registered with the Drug Enforcement Agency (DEA). If there is no qualified registered pharmacist, the responsible physician may use his or her registry number to obtain stock supplies of controlled substances. A physical inventory of controlled substances is required every two years, or more frequently at the demand of the Board of Pharmacy.

When stock medications are maintained within a detention facility, there must be a formulary of the available medications. A formulary serves two major purposes: 1) cost containment is improved by eliminating costly duplication of expensive treatment alternatives; and 2) a

reference list of readily available medications is maintained for the treatment staff. The physical isolation of some jail facilities can make it difficult to obtain medications for inmates promptly, so keeping a stock of commonly used medications may improve efficient treatment in a cost-effective manner. It is acceptable to administer stock legend (prescription) medications by removing single doses at a time, provided this is done by licensed health care staff; only a physician or pharmacist can package multi-dose packages of medication from bulk stock.

Carefully adhere to procedures for the proper disposal of legally obtained drugs and supplies after their period of use. Dated medications should be routinely purged from stock after their period of use or expiration dates. Facilities that rely on community pharmacies should work with those pharmacists to develop written policies and procedures for destruction of unused drugs. Consideration should be given to incorporating this responsibility into the facility's contract for pharmaceutical services. In larger systems with in-house pharmacies, an inventory of controlled medications to be destroyed must be developed and signed by two licensed health professionals in accordance with the State Board of Pharmacy regulations. This record must be maintained for three years. Policies and procedures for returning unused medications to the pharmaceutical company may be more advantageous than in-house destruction.

Equipment such as used needles and syringes, must be disposed of in puncture-resistant containers and discarded according to currently accepted medical waste disposal procedures. Due to increasing awareness of risks for acquiring hepatitis and HIV infections through cutaneous injury by blood-contaminated sharp instruments, it is no longer recommended that contaminated disposable needles be re-sheathed or broken prior to disposal. County environmental health departments are a resource to assist in developing policies in this area.

It is crucial that the inmate for whom a dose of a particular medication is intended is the inmate who receives that medication. **Subsection (a)(2)** requires clear policy, consistently followed, regarding positive identification of recipients of medication. One option is hospital-type identification wristbands, photographs on medication records or I.D. cards. This option, while not required, should be seriously considered. Particularly in receiving facilities and facilities with more than a handful of inmates, it is impossible to identify inmates by recognition only. Staff should not rely on knowing inmates by face.

Subsection (a)(3) addresses the administration and delivery of medications to inmates. (See **Section 1006, Definitions**) It is important to distinguish between "dispensing," "administering" and "delivering" medications. Licensed medical staff are not the only personnel who can deliver medications, but they are the only ones who can dispense and administer them.

1. Dispensing medications can be defined as compounding, packaging, preparing, counting, labeling or in any way filling a prescription. Dispensing can only be done by a licensed physician or pharmacist.

2. Administering refers to the act in which a single dose of a prescribed drug is given to the patient from a bulk container of medication. This can only be done by a licensed medical person, one dose at a time, in accordance with law and regulation. Custody staff cannot administer a dose of medication from a bulk container.

3. Delivery can be done when there is a properly labeled prescription container (i.e., a dated container which includes the name of the individual for whom the drug is prescribed, the name of the medication, dose and instructions for taking the medication, the name of the prescribing physician and expiration dates). Under these circumstances, a single dose at a time can be delivered to the inmate according to the written instructions any licensed nursing personnel or custody staff.

When a inmate is given medication under any of these circumstances, it is important to verify the dose with the prescriber's orders, give the individual dose to the proper inmate and promptly record the time, dose and name of the person giving the dose.

Given the realities of the custody setting, it is often difficult to provide medications on an ideal schedule. There are some medications that have to be given more frequently than others and some that have to be taken on an empty stomach. These and other issues mean health and custody staff must have written policy and procedures for melding jail operations and custody concerns with the medical and mental health needs of inmates. Inmate movement, court appearances and conflicting activities all interfere with scheduled "pill calls." Jails should consider methods for providing critical medications to those individuals who are attending court, working in areas not routinely accessible to medical staff, and those who are being transported elsewhere. It may be helpful for the prescribing physician to indicate in the medication orders how much leeway is reasonable and safe for a given medication and patient.

Long acting formulations of medications are becoming increasingly available and are attractive for use in custody settings because they are given less frequently and allow for reduced staff involvement. Some health systems routinely crush or place certain drugs (e.g., pain or psychotropic medications) in water, believing that liquefying the medications will improve inmate compliance with ingestion. If such long acting formulations are used, it is important to realize that "soaking" medications in water prior to administration is likely to affect the absorption pattern, thus interfering with sustained release characteristics of some drug preparations.

Generally speaking, it is not advisable to use an inmate's personal medications brought by family or friends. Best practice is for the facility to purchase medications that are used inside the institution; however, there are situations where the medication is difficult purchase, etc. and to ensure continuity of care, personal medications may be used. There should be written procedures guiding this practice. In such instances, the prescription should be current (dated within the last two weeks or, for chronic medications, within the past three months) and the contents of the container(s) should be examined for positive identification and approved by the facility's responsible physician or designee. For security reasons, it is preferable that no medication from any source other than the facility or system is used; however, this is not always possible. If prescription medications brought into the facility, they should be recorded on the inmate property record and stored in a secure area until the inmate's release.

It is appropriate to use medications transferred from other detention facilities if there is a secure method for ensuring that individual inmate prescriptions are not tampered with between facilities and that containers are properly labeled.

Subsection (a)(4) calls for procedures for confirming that the recipient has ingested the medication given to him or her. It is important to the treatment of many illnesses, tuberculosis prime among them, that medications be ingested on a regular schedule and that staff observe the ingestion. Additionally, this subsection requires that if facility policy allows certain inmates to maintain their own supplies of certain medications [**Subsection (d)**], there must be a method of accounting for those medications.

Further, ensuring that inmates take their medications when administered is an issue related to institution and inmate security. Inmates must not be sequestering their prescription medications for later use as currency, for accumulation, or for ingestion in an effort to overdose. This creates the opportunity for inmates to intimidate others into saving and sharing medications.

The use of liquid formulations may be considered for psychotropic and other controlled medications, as these are more difficult to sequester; however, there are some downsides to liquid formulations. For example, not all drugs are available in liquid form, the bad taste of most liquids or powders could discourage inmates from accepting treatment, and the high cost of liquid forms of medications could be prohibitive. Nonetheless, liquid medications solve some ingestion problems that may make the additional cost worthwhile in some instances.

Watching an inmate take prescription medications is "directly observed therapy" (DOT). This regulation requires DOT to ensure that the drugs are ingested. Ingestion of tuberculosis medications should always be observed. Since nursing staff often cannot get to the sites of many work crews, there must be policy related to DOT for those inmates, when appropriate.

As noted in **Section 1200, Responsibility for Health Care Services,** Type IV facilities relate to the pharmaceutical regulations differently from other types of facilities. The regulation is intended to apply to "in custody" inmates, not those under constructive custody in the community. Type IV facilities should consider this an "as applicable" regulation. If a facility delivers medications to inmates, it must follow all the applicable elements of this regulation. Because personnel of Type IV facilities will not be able to actually observe inmates taking their medications when out of the facility, policy and procedures may say that inmates will be observed while in the facility, but will be responsible for self-administration of medications while at work or school in the community.

Record keeping related to legally obtained drugs and medications is a key part of operating a jail's health services program. **B & P Code Section 4232** requires that pharmaceutical records, including inventories of those medications not used and therefore destroyed, be kept for three years. Additionally, drug companies require detailed records of unused drugs that are returned to them. Pursuant to **Subsection (a)(5)**, the health authority is responsible for overseeing medications and monitoring records of dispensed medications. Recording must be thorough, including reasons why a prescribed medication was not administered, (e.g., inmate was in court, inmate slept through pill call, inmate refused medication, etc.). The more detailed the documentation, the greater protection it affords the facility's personnel.

Rapid turnover of jail populations and the resulting possibility of individuals being "lost in the system," as well as good medical practice, dictate that there be a policy, as called for in **Subsection (a)(7)**, which limits the length of time medication may be administered without

further evaluation. Medication should not be administered over extended periods of time without routine follow up to assure medication efficacy, continued need for treatment and absence of complications. At a minimum, follow up should be scheduled with the same frequency as is customary in the community for the particular condition. Given the destabilizing effects of the jail environment (e.g., changes in diet and exercise, situational stress, relative enforcement of medication compliance, etc.), more frequent clinic visits are often warranted. The ordering of chronic medications for an indeterminate time (e.g., until release) fails to meet usual standards of care. For patients on stable medication regimens, follow up visits at least every one to three months is recommended.

"Stop orders" are a special consideration for drugs with recognized abuse potential. With the high rate of substance abuse in jail populations, it is essential that practices to discourage the development or continuation of drug dependency be incorporated into the prescribing habits of jail practitioners. Policies may need to include a requirement to reevaluate the need for habit-forming medications every seven to fourteen days.

Subsection (a)(8) requires a policy describing the length of time within which a physician's verbal orders must be put in writing and signed by that physician. Signing of medical orders pertaining to the general medical care of inmates should be compatible with community standards (usually 72 hours). In the case of psychotropic medications **(Section 1217, Psychotropic Medications)**, initiation of non-emergency therapy must include obtaining informed consent from the patient by a qualified professional **(Section 1214, Informed Consent)**. As a general rule, the use of verbal orders is limited to minor aspects of care and cannot take the place of on-site evaluation and treatment. Reviewing the number and types of telephone orders is an important aspect of the quality review or management process referenced in **Section 1202, Health Service Audits**.

As noted in **Subsection (a)(9)**, at least annually, a pharmacist must prepare reports on the status of pharmacy services in the institution. The pharmacist is responsible to the health authority and facility/system administrator, and these reports should be incorporated into the medical audit required by **Section 1202, Health Service Audits**. It is vitally important that any problems with regard to pharmaceutical management be discussed in the annual audit report. The Board of Pharmacy licenses pharmacies in some local detention facilities and performs inspections that include a review of pharmacy services. When this occurs, the Board of Pharmacy report may be considered the annual pharmacist report for purposes of this regulation.

Subsection (c) addresses the importance of having policy and procedures for management of over-the-counter (OTC) medications. If custody staff delivers OTC medications, it is recommended that the delivery be documented; this helps in the identification and referral of inmates with chronic complaints that have not been evaluated, helps avoid untoward drug interactions or complications, and helps prevent hoarding and trading of drugs.

Jails can sell over-the-counter medications in the commissary so inmates can institute self-care or purchase medications recommended during a nursing sick call. If a system elects this method, it must provide timely access to the commissary and every facility that has over-the-counter medication available, whether for sale or administered by non-medical staff, should provide self-care information to inmates. They must maintain the medications for self-treatment in the same

kinds of containers and/or with the same retail labeling information as in the open community. If over-the-counter medications are made available for purchase, the facility administrator and health authority should describe the process in written policy and procedure which medications will be sold; limitations on the amounts of medications inmates can purchase and/or hold; how over-the-counter medications will be provided to indigent inmates unable to purchase them; and how to deal with those who should not have access to over-the-counter medications, such as inmates in disciplinary housing, those with high suicide potential, etc.

Subsection (d) describes the parameters for a facility to allow certain inmates to maintain their own supplies of selected medications. The regulation is prescriptive about issues that, at minimum, must be addressed in policy and procedures for self-medication. Essentially, medications that can be self-administered are those that have no recognized potential for abuse. Tuberculosis medications, psychotropic medications, controlled substances, injectables, and any medication for which documentation of ingestion is essential must continue to be provided under direct observation of staff.

Inmates must have both the intellectual ability to understand and the willingness to follow the rules of the program. Those with histories of frequent rules violations, and those who violated the program rules in the past, are not allowed to maintain and administer their own medications. If the medication is on kept on the inmate's person, there must be provision for secure storage. For a self-administration program to work, both custody and health care staff must support the policies and procedures and consistently enforce the rules. Health care staff must have procedures for documented assessments of an inmate's compliance with completing their regimen of medication. Local policy will drive the frequency of these assessments, but they must be done frequently enough to protect the inmate's health and prevent hoarding.

Automation of pharmaceutical records can provide some relief to a burdened manual record keeping system, especially in larger facilities. Automated record keeping increases the ability to monitor patterns of prescribing, to detect patterns of inmate requests for drugs and to monitor the efficiency of the pharmacy service. An automated record keeping system may reduce record storage problems, reduce retrieval time for patient health care histories, increase accuracy in record keeping overall and even make the monitoring of over-the-counter drugs easier.

Detention facilities with full-time pharmacy and medical staff may decide to maintain a "Pharmacy and Therapeutic" subcommittee as part of their total quality management process. Included on the committee should be the responsible physician, a pharmacist, director of nursing services and the director of mental health services. This subcommittee should be responsible for developing written policies and procedures to establish safe and effective systems for the procurement, storage, distribution, dispensing and use of drugs. This subcommittee would develop and maintain a formulary of drugs for use throughout the local detention system. Using such a subcommittee is an effective method of ensuring quality through the conduct of the annual audit of procedures, chart reviews and monitoring of prescription practices.

1217. Psychotropic Medications.

The responsible physician, in cooperation with the facility administrator, shall develop written policies and procedures governing the use of psychotropic medications. An inmate

found by a physician to be a danger to him/herself or others by reason of mental disorders may be involuntarily given psychotropic medication appropriate to the illness on an emergency basis. Psychotropic medication is any medication prescribed for the treatment of symptoms of psychoses and other mental and emotional disorders. An emergency is a situation in which action to impose treatment over the inmate's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.

If psychotropic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition. The medication shall be prescribed by a physician in written form in the inmate's record or by verbal order in dosage appropriate to the inmate's need. Verbal orders shall be entered in the inmate's record and signed by a physician within 72 hours. The responsible physician shall develop a protocol for the supervision and monitoring of inmates involuntarily receiving psychotropic medication.

Psychotropic medication shall not be administered to an inmate absent an emergency unless the inmate has given his or her informed consent in accordance with Welfare and Institutions Code Section 5326.2, or has been found to lack the capacity to give informed consent consistent with the county's hearing procedures under the Lanterman-Petris-Short Act for handling capacity determinations and subsequent reviews.

There shall be a policy which limits the length of time both voluntary and involuntary psychotropic medications may be administered and a plan of monitoring and re-evaluating all inmates receiving psychotropic medications, including a review of all emergency situations.

The administration of psychotropic medication is not allowed for disciplinary reasons.

Guideline: Please see **Section 1209, Transfer to a Treatment Facility** and **Section 1214, Informed Consent**, for a discussion of issues related to this regulation. This regulation applies to any facility in which psychotropic medications are administered, but has particular significance for those that undertake treatment on an involuntary basis. Most commonly, this will be limited to Type II and III facilities, although some larger Type I facilities may also have the health care resources for such treatment. Aspects of the regulation relating to policies for voluntary administration of psychotropic medications also apply to Type IV facilities.

This regulation recognizes that a facility will be in a better position to defend practices that mirror those in the local community. In other words, unless statute specifies otherwise, the same principles of medical/mental health practice and preserving patients' rights apply in jails. This means that psychotropic medications must be given with full understanding and consent of the patient (except in emergencies, as discussed below), and persons involved in making the diagnosis and treatment decisions must carefully adhere to the boundaries of their training and licensure.

In spite of obvious shortages of mental health treatment facilities in most communities, it is important that jails do not attempt to become unlicensed substitutes for such facilities merely because they are the "port of last resort." Persons with suspected severe mental disorders may actually be medically ill and at risk for deterioration and even death if not properly diagnosed. In addition, treatment with medications, particularly those that are given on an involuntary basis,

can result in serious side effects that require close medical monitoring. Consequently, it is crucial that persons whose conditions cannot be readily diagnosed and brought under control be transferred promptly to a treatment facility that is equipped to meet these needs. While a few jails operate licensed mental health units, most find it necessary to refer to community based facilities. Jail administrators should bear in mind their option under **Penal Code Section 4011.6** to transfer a disordered inmate to a treatment unit for 72-hour treatment and evaluation pursuant to **Section 5150 of the W & I Code**. At a minimum, initiating a transfer under **Penal Code Section 4011.6** should result in an evaluation (which can be conducted at the jail) by the mental health director or designee. In addition, transfer for treatment on a voluntary basis is possible under **Penal Code Section 4011.8 (Section 1209, Mental Health Services and Transfer to a Treatment Facility)**.

The issue of involuntary treatment in jails is a source of controversy. Many facilities choose to prohibit involuntary treatment altogether. Others, by virtue of the prevalence of severe mental illness in their population, or because of long distances separating them from treatment facilities, find it necessary to make provisions for intervention at the jail site. Facilities which choose to undertake involuntary mental health treatment in the absence of operating a fully licensed treatment program must be prepared to justify their procedures as being comparable to those which would apply in the open community.

The diagnosis of a mental disorder necessitating intervention should be made by a health care professional trained and licensed to perform such an evaluation. (In general, this would be a physician; under rare circumstances, it might be a registered nurse or physician's assistant with telephone communication with a physician who would later examine the patient to verify the diagnosis. It is not essential that the physician be a psychiatrist; however, the physician should be trained and competent in management of mental disorders.) The less that is known about an inmate's psychiatric and medical history, the more crucial is the immediate and hands-on involvement of a physician. Initiation of involuntary psychotropic medications without a physician first examining the inmate is strongly discouraged. Medications must not be utilized as a convenience, as that practice is hazardous from a medical point-of-view, particularly when undertaken in non-medical settings, and subject to considerable liability for detention administrators. Using sufficient, but the least restrictive option, is medically the safest approach and most defensible legally with respect to patients' civil liberties.

Under these regulations, involuntary treatment can be initiated only in the case of an emergency. "Emergency" is strictly limited to those circumstances in which the inmate's mental disorder is considered to pose imminent threat of harm to self or others: "a situation in which action to impose treatment over an inmate's objections is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impractical to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment." In such cases, the physician may proceed to medicate an inmate in order to avert that immediate threat.

Only that type and amount of medication necessary to deal with the emergency itself can be provided under emergency circumstances. If the emergency is not resolved with a single dose of medication, or if the patient does not then continue treatment on a voluntary basis, consideration should be given to prompt transfer of the inmate to a treatment facility. If the diagnosis is in

doubt, physical restraint and rapid transfer is preferable to medicating involuntarily, since the effects of the medication may obscure a diagnosis when the inmate is ultimately evaluated. Repeated administration of involuntary medication ("perpetual emergencies") becomes increasingly difficult to justify from both a medical/mental health practice and a legal standpoint. Likewise, it is inappropriate to administer long-acting, injectable, anti-psychotic medications, which are designed for maintenance treatment, under emergency circumstances. Treating health care staff must document justification of the emergency in the medical record each and every time that it occurs. It is clearly preferable that physicians write orders for medication after examining an inmate and prior to implementation of treatment; in an extreme situation where that is not possible, the order may be issued verbally or by telephone but must be signed by the physician within 72 hours.

There must be procedures in place to require a formal review of each emergency in which medications are administered involuntarily. At a minimum, this review process should involve the county mental health director or designee, the treating physician, and a custody representative. The purpose of such a review is to assure that practices within the jail setting withstand the scrutiny of community practice standards. It also sends the important message that involuntary treatment is a serious intervention that should not be undertaken casually. The review process is an opportunity to discuss options for managing disordered behavior and to assure that less restrictive approaches are first utilized whenever possible.

If jail treatment staff believe that an inmate would benefit from treatment with psychotropic medications for a period of time beyond an immediate emergency, the inmate must either provide informed consent or a competency hearing must first be conducted. The approach to such a hearing should be equal to, or parallel, the capacity hearing procedures that are used by the county mental health department under the LPS Act. Although allowances can be made to accommodate legitimate security issues, the process should contain the essential elements to safeguard the inmate/patient's rights to due process. Some counties already have procedures that meet the requirements of **Riese v. St. Mary's Hospital** capacity hearings.[10] If these procedures are not used, similar procedures established to meet the requirements of the LPS Act should be used. A determination that an inmate lacks capacity for providing informed consent must be formally reviewed at intervals consistent with requirements of the LPS Act and schedules already established by the county's mental health director for non-incarcerated patients. This prevents situations in which inmates could otherwise be indefinitely treated without consent, even if the capacity for decision-making has been restored.

Some local detention facilities have developed procedures for competency hearings, and forced psychotropic medications. In the majority of instances, they have a county designated LPS unit inside their facility. If a facility is considering developing policies and procedures allowing ongoing forced medications, and establishing an LPS unit, jail administrators should consult with their county counsel and work with their facility and county mental health director. The important components are those which assure that the inmate/patient has representation by a patients' rights advocate or attorney who is completely independent of the criminal justice system and that the hearing officer is similarly disinterested. Counties that do not have their own

[10] Riese v. St. Mary's Hospital is case law which has defined requirements for competency hearings for hospitalized mental health patients in the community, now codified in the W & I Code, Section 5332, et seq.

inpatient mental health facilities should establish procedures for referral to nearby treatment units and initiation of hearing procedures in the usual fashion associated with that unit.

This regulation uses a broader term that encompasses medications other than those solely defined as "anti-psychotic." The term "psychotropic medications" applies to any medication whose purpose is to have an effect on the central nervous system to impact behavior or psychiatric symptoms. Psychotropic medications include, but are not limited to, anti-psychotic, anti-depressant, lithium carbonate and anxiolytic drugs, as well as anti-convulsants or any other medication when used to treat psychiatric conditions. This definition acknowledges current trends in treatment, which include a wide array of medications utilized in treating mental disorders. According to these regulations, if a medication is being prescribed with the intent of modifying an inmate's behavior or psychiatric symptoms, it should be prescribed and monitored in the same manner that has elsewhere applied to anti-psychotic medications.

While all non-emergency medical and mental health care requires the understanding and agreement of the inmate, there is special emphasis on "informed consent" in the case of psychotropic medications. This has to do with several considerations including: (a) implications of a psychiatric diagnosis and treatment in an inmate's case, including ability to participate in their defense during criminal proceedings; (b) potential for behavior control (i.e., "medical restraint"); and (c) possibilities of serious side effects. Obtaining informed consent from the inmate is defined in the **W & I Code Section 5326.2** [11] and requires that the prescribing physician discuss the following information: (1) the nature of the mental illness or behavior that is the reason the medication is being given or recommended; (2) the likelihood of improving or not improving without the medications; (3) reasonable alternative treatments available; (4) the name and type, frequency, amount, and method of administering the medications, and the probable length of time that the medication will be taken; and (5) anticipated or possible side effects associated with the medication (**Section 1214 Informed Consent**). Although documenting this discussion in the medical record is minimally adequate, it is common practice (and sometimes required as a condition of funding by certain programs) to use a detailed consent form. In either case, the inmate's agreement with treatment must be clearly ascertained. Under no circumstances can psychotropic medications be used as a disciplinary tool or to control behavior that is not the result of a mental disorder.

Good medical and mental health practice requires periodic monitoring for efficacy of treatment and identification of side effects. While this regulation imposes parameters describing the length of time involuntary psychotropic medications can be administered (i.e., immediate emergencies or as determined through a hearing process), this regulation also requires that there be policy which establishes the minimum time frames for re-evaluating inmates who are maintained on psychotropic medications voluntarily. This regulation does not seek to extend these time frames beyond those allowed in the community. At a minimum, it seeks to mimic those standards established for non-incarcerated mental health patients. The ordering of psychotropic medications "until release" is unacceptable. Because jail inmates tend to be inherently less stable than their counterparts in the free community, there is a strong argument to be made for monitoring their progress on a somewhat more frequent basis. Some facilities choose to limit voluntary psychotropic medication orders to 30 days or less, in contrast to a common community

[11] This section applies to persons who are involuntarily detained for the purpose of mental health evaluation and treatment.

practice of 90 days. This approach serves to trigger a re-evaluation of the inmate in conjunction with renewal of the medication

1219. Suicide Prevention Program.

The facility administrator and the health authority shall develop a written plan for a suicide prevention program designed to identify, monitor, and provide treatment to those inmates who present a suicide risk.

Guideline: The written suicide prevention plan, developed collaboratively by custody, medical and mental health staffs, must be designed to recognize, identify, monitor, intervene with and provide treatment to those inmates who present a suicide risk. The program is to operate in all detention areas of all facilities.

Properly trained custody personnel can effectively assess suicide potential both at the time of booking and during subsequent phases of the inmate's incarceration. Initial receiving screening **(Section 1207, Medical Receiving Screening)** and observation by intake, booking and housing staff are imperative to suicide prevention. Intake screening must be performed on every arrestee immediately upon entry into the facility. Those individuals who refuse such screening should be placed under special observation until such time as receiving screening can be completed or longer term decisions can be made concerning their housing and management. Although receiving screening can detect a great portion of potentially suicidal behavior, inmates can become suicidal at any stage of their incarceration; thus, continued observation and awareness of potentially suicidal behavior is an added key to prevention. It may be useful to keep records of suicide attempts and successful saves or interventions, not only for purposes of correcting perceived problems but also because such information will help build a defense to lawsuits.

Some key suicide risk factors identified in national studies follow:

From the inmate's perspective, there are certain unique characteristics of jail environments that enhance suicidal behavior. These include:

- fear of the unknown;
- authoritarian environment;
- no apparent control over the future;
- isolation from family and significant others;
- shame of incarceration; and,
- dehumanizing aspects of incarceration.

When examining potentially suicidal behavior, the following predisposing factors are commonly found:

- recent excessive drinking and/or use of drugs;
- recent loss of stabilizing resources;
- severe guilt or shame over the offense;
- same sex rape or threat of rape;
- current mental illness;

- poor physical health or terminal illness; and,
- approaching an emotional breaking point.

The high risk suicide periods for inmates correlate with phases of their incarceration or steps in the criminal justice process. These periods include:

- the first 24 hours of confinement;
- intoxication/withdrawal;
- trial and sentencing hearings;
- impending release;
- decreased staff supervision;
- weekends and holidays; and,
- bad news from home.

Signs and symptoms exhibited by the inmate often foretell a possible suicide and, if detected, could prevent such an incident. What the individual says and how he or she behaves while being arrested, transported to the jail and/or booked are vital for detecting suicidal behavior. An individual may exhibit warning signs and symptoms that include:

- depression (physical signs)
  - sadness and crying,
  - withdrawal or silence,
  - sudden loss or gain in appetite,
  - insomnia,
  - mood variations,
  - lethargy;
- intoxication/withdrawal;
- talking about or threatening suicide;
- previous suicide attempts;
- history of mental illness;
- projecting hopelessness or helplessness;
- speaking unrealistically about the future and getting out of jail;
- increasing difficulty relating to others;
- not effectively dealing with present, is preoccupied with past;
- giving away possessions, packing belongings;
- severe aggressiveness; and,
- paranoid delusions or hallucinations.

Correctional staff must closely observe any inmate who reports or has a known history of suicide gestures until the inmate can be seen by mental health services staff. While not a substitute for close staff observation, it may be preferable to house some suicidal inmates with other non-threatening inmates.

It can be useful to use a "suicide prevention team" to annually scrutinize a facility to identify any physical plant characteristics or operational procedures which might be modified to reduce the risk of suicide. The suicide prevention team membership should include custody, medical and mental health staff, and their goal should be to focus on all detention areas within the facility.

It is vitally important that there be training for all custody and health care staff in suicide prevention and crisis intervention. This training, because it is essential to optimal jail operations, is required by **Sections 1020, Corrections Officer Core Course; 1021, Jail Supervisory Training; 1023, Jail Management Supplemental Training** and **1024, Court Holding and Temporary Holding Facility Training**.

1220. First Aid Kit(s).

First aid kit(s) shall be available in all facilities. The responsible physician shall approve the contents, number, location and procedure for periodic inspection of the kit(s). In Court and Temporary Holding facilities, the facility administrator shall have the above approval authority, pursuant to Section 1200 of these regulations.

Guideline: The purpose of the first aid kit is to provide emergency medical supplies for applying aid pending the arrival of trained medical staff. This regulation requires physician approval for the contents and location of first aid kits. In court and temporary holding facilities where there is no responsible physician, the facility administrator establishes the contents and location **(Section 1200, Responsibility for Health Care Services)**. Policy and procedures should assure that staff understand their responsibilities with respect to providing first aid and have the necessary skills and training to perform these responsibilities. It is important that all custody staff be trained in the use of each item in the kit and that this training be updated regularly. The contents must reflect the type of first aid equipment and procedures needed to respond to anticipated types of injuries (e.g., a kitchen first aid kit differs from that of a fire camp).

Some facilities may choose not to have first aid kits because they have medical staff on the premises 24 hours a day, seven days a week and this constitutes their "first aid" response. When this is done, the responsible physician must approve the absence of first aid kits and the **Health Care Procedures Manual** required by **Section 1206** must describe how this first aid response is to occur. Policies should define custody and medical staff responsibilities.

The estimated time of arrival of trained emergency medical personnel and the possibility that emergency crews may not be available should be considered in the facility first aid plan. In the usual detention setting, excluding kitchens or other work crew areas, emergencies which can be anticipated include: cardio-respiratory collapse or distress; fights and/or falls resulting in hemorrhage, sprains or broken bones; and, shock resulting from trauma, hemorrhage or fractures. Maintain those supplies that will be needed in these, and any other emergencies covered in the facility's written procedures on first aid. For example, if a person is hemorrhaging and written instructions allow for the placement of a tourniquet under defined circumstances, then in addition to compresses for direct pressure control, the kit would also contain a tourniquet.

The kit itself should be durable, fireproof, portable and designed to keep out dust. Select the contents based upon the known use and anticipated needs of the location the kit is intended to serve (e.g., the kit located in the kitchen area might contain supplies that are not contained in kits located elsewhere in the facility). The policy and procedures for use of the kit will include the steps for inventorying and restocking.

1230. Food Handlers.

The responsible physician, in cooperation with the food services manager and the facility administrator, shall develop written procedures for medical screening of inmate food service workers prior to working in the facility kitchen. Additionally, there shall be written procedures for education and ongoing monitoring and cleanliness of these workers in accordance with Section 114020 of the Health and Safety Code, California Uniform Retail Food Facilities Law.

Guideline: The purpose of the first aid kit is to provide emergency medical supplies for applying aid pending the arrival of trained medical staff. This regulation requires physician approval for the contents and location of first aid kits. In court and temporary holding facilities where there is no responsible physician, the facility administrator establishes the contents and location **(Section 1200, Responsibility for Health Care Services)**. Policy and procedures should assure that staff understand their responsibilities with respect to providing first aid and have the necessary skills and training to perform these responsibilities. It is important that all custody staff be trained in the use of each item in the kit and that this training be updated regularly. The contents must reflect the type of first aid equipment and procedures needed to respond to anticipated types of injuries (e.g., a kitchen first aid kit differs from that of a fire camp).

Some facilities may choose not to have first aid kits because they have medical staff on the premises 24 hours a day, seven days a week and this constitutes their "first aid" response. When this is done, the responsible physician must approve the absence of first aid kits and the **Health Care Procedures Manual** required by **Section 1206** must describe how this first aid response is to occur. Policies should define custody and medical staff responsibilities.

The estimated time of arrival of trained emergency medical personnel and the possibility that emergency crews may not be available should be considered in the facility first aid plan. In the usual detention setting, excluding kitchens or other work crew areas, emergencies which can be anticipated include: cardio-respiratory collapse or distress; fights and/or falls resulting in hemorrhage, sprains or broken bones; and, shock resulting from trauma, hemorrhage or fractures. Maintain those supplies that will be needed in these, and any other emergencies covered in the facility's written procedures on first aid. For example, if a person is hemorrhaging and written instructions allow for the placement of a tourniquet under defined circumstances, then in addition to compresses for direct pressure control, the kit would also contain a tourniquet.

The kit itself should be durable, fireproof, portable and designed to keep out dust. Select the contents based upon the known use and anticipated needs of the location the kit is intended to serve (e.g., the kit located in the kitchen area might contain supplies that are not contained in kits located elsewhere in the facility). The policy and procedures for use of the kit will include the steps for inventorying and restocking.

ARTICLE 12. FOOD

1240. Frequency of Serving.

In Temporary Holding, Type I, II, and III facilities, and those Type IV facilities where food is served, food shall be served three times in any 24-hour period. At least one of these meals shall include hot food. Supplemental food must be served to inmates if more than 14 hours pass between meals. Additionally, supplemental food must be served to inmates on medical diets in less than a 14-hour period if prescribed by the responsible physician.

A minimum of fifteen minutes shall be allowed for the actual consumption of each meal except for those inmates on medical diets where the responsible physician has prescribed additional time.

Provisions shall be made for inmates who may miss a regularly scheduled facility meal. They shall be provided with a substitute meal and beverage, and inmates on medical diets shall be provided with their prescribed meal.

Guideline: This regulation applies to temporary holding, Type I, II, and III facilities and Type IV facilities where food is served. It requires that food must be served three times in any 24-hour period. Many corrections professionals believe that good food is a key element in inmate management. The regulation requires only one hot meal a day, but food service managers should consider the costs and benefits associated with serving more than one hot meal. An assumption that it is more cost effective to prepare and serve only one hot meal may not be accurate; two cold meals each day may require additional costs for cold storage. There may also be added costs associated with containers and wrapping that are not associated with hot meals. Another factor to consider is climatic conditions. In areas that experience cold weather, it may be especially beneficial to provide two hot meals; however, if the weather is very warm, one hot and two cold meals may be a more reasonable approach.

Inmates must have a minimum of 15 minutes to consume each meal. In the case of a medical diet, this time frame may need to be extended. The minimum time can be extended for any meal at the discretion of the facility manager, in consultation with the responsible physician.

The regulation describes situations in which supplemental food or a substitute meal and beverage must be served in addition to, or in place of, a regularly scheduled meal. Supplemental food shall be provided to inmates if more than 14 hours elapses between meals, and when prescribed by a physician for those inmates on medically prescribed diets. Examples of supplemental foods include soup, a sandwich, fruit, or other nutritious food. A substitute meal and beverage is required whenever a regularly scheduled meal is missed.

The regulation does not address the provision of food for inmates who are admitted to the facility after missing a meal on the outside (e.g., someone who comes in at 2 p.m. and indicates that he didn't have breakfast or lunch before being arrested). Typically, the jail has no obligation to provide food until the next regularly scheduled meal; however, there are instances when inmates have been in custody in outlying facilities and may have missed meals due to no fault of their own. Providing some food may be a reasonable option. Also, certain conditions, such as diabetes or pregnancy, make it advisable for facility managers to have options for making food

available. Some jurisdictions also have court-imposed expectations regarding nutrition for persons arrested for public inebriation who are awaiting release.

1241. Minimum Diet.

The minimum diet provided shall be based upon the nutritional and caloric requirements found in the 1999-2002 Dietary Reference Intakes (DRI) of the Food and Nutrition Board, Institute of Medicine of the National Academies, the 1990 California Daily Food Guide, and the 2000 Dietary Guidelines for Americans. Facilities electing to provide vegetarian diets, and facilities that provide religious diets, shall also conform to these nutrition standards. The nutritional requirements for the minimum diet are specified in the following subsections. A wide variety of food should be served.

(a) Protein Group. Includes beef, veal, lamb, pork, poultry, fish, eggs, cooked dry beans, peas, lentils, nuts, peanut butter and textured vegetable protein (TVP). One serving equals 14 grams or more of protein; the daily requirements shall be equal to three servings. In addition, there shall be a requirement to serve a fourth serving from the legumes three days a week.

(b) Dairy Group. Includes milk (fluid, evaporated or dry; nonfat, 1% or 2% reduced fat, etc.); cheese (cottage, cheddar, etc.); yogurt; ice cream or ice milk; and pudding. A serving is equivalent to 8 oz. of fluid milk and provides at least 250 mg. of calcium. All milk shall be pasteurized and fortified with Vitamins A and D. The daily requirement is three servings. For persons 15-17 years of age, or pregnant and lactating women, the requirement is four servings. One serving can be from a calcium-fortified food containing at least 250 mg. of calcium.

(c) Vegetable-Fruit Group. Includes fresh, frozen, dried and canned vegetables and fruits. One serving equals: 1/2 cup vegetable or fruit; 6 ounces of 100% juice; 1 medium apple, orange, banana, or potato; 1/2 grapefruit; or 1/4 cup dried fruit. The daily requirement of fruits and vegetables shall be five servings. At least one serving shall be from each of the following three categories:

(0) One serving of a fresh fruit or vegetable.
(0) One serving of a Vitamin C source containing 30 mg. or more.
(0) One serving of a Vitamin A source, fruit or vegetable, containing 200 micrograms Retinol Equivalents (RE) or more.

(d) Grain Group. Includes bread, rolls, pancakes, sweet rolls, ready-to-eat cereals, cooked cereals, corn bread, pasta, rice, tortillas, etc. and any food item containing whole or enriched grains. At least three servings from this group must be made with some whole grains. The daily requirements shall be a minimum of six servings.

The following bread-cereal products meet the partial or whole grain requirement:

oatmeal	**whole wheat bread**
pumpernickel bread	**corn tortilla**
whole wheat rolls	**whole grain hot cereal**
whole wheat flour	**grits**
tortilla	**whole grain pancakes**

whole grain bagels, muffins, and crackers
whole grain ready-to-eat cereal
and waffles

Providing only the minimum servings outlined in this regulation is not sufficient to meet the inmates' caloric requirements. Additional servings from the dairy, vegetable-fruit, and bread-cereal groups must be provided in amounts to meet caloric requirements. In keeping with chronic disease prevention goals, total dietary fat should not exceed 30 percent of total calories on a weekly basis. Fat shall be added only in minimum amounts necessary to make the diet palatable.

Guideline: The requirements outlined in this regulation reflect the new dietary reference values for the intake of nutrients by Americans released in a series of reports from 1999-2002 by the Food and Nutrition Board of the Institute of Medicine, the National Academies. The 2001 Dietary References Intakes (DRI) expands and replaces the formerly used Recommended Dietary Allowances (RDAs). The DRIs are reference values that are quantitative estimates of nutrient intakes to be used for planning and assessing diets for healthy individuals. They include RDAs as goals for intake by individuals but also include additional types of reference values.

The menus and requirements described in this regulation reflect the current sources of information found in the DRIs of the **Food and Nutrition Board, Institute of Medicine of the National Academies**, and the **1990 California Daily Food Guide**, published by the Department of Health Services. The reference for subsections (a), (b), (c), and (d) is the 2001 DRI, **1990 California Daily Food Guide**. This information is essential to determine serving size.

Subsection (a) addresses the Protein Group and includes beef, veal, lamb, pork, poultry, fish, eggs, cooked dry beans, peas, lentils, nuts, peanut butter and textured vegetable protein (TVP). One serving equals 14 grams or more of protein; the daily requirements shall be equal to three servings. In addition, there shall be a requirement to serve a fourth serving from the legumes three days a week.

In the Protein Group, there has been confusion with regards to foods that can be served to fulfill the legume requirement. According to the **2005, Eighteenth Edition of Bowes & Church's, Food Value of Portions Commonly Used**, green peas and lima beans are categorized as legumes; therefore, they can be served to fulfill the legume requirement. For example, one cup of green peas and one half cup of lima beans will fulfill one serving of the legume requirement.

One serving equals, but is not limited to, the following examples:

6 oz. Tofu	2 medium eggs
1 cup cooked dry beans, peas or lentils	3 Tbsp. Peanut butter
½ cup seeds	2/3 cup nuts
2 to 3 oz. (without bone) lean, cooked meat, poultry or fish	2¼ oz. dry TVP or 1 cup rehydrated, canned or frozen TVP

Subsection (b) addresses the Dairy Group and includes milk (fluid, evaporated or dry; nonfat, 1% or 2% reduced fat, etc.); cheese (cottage, cheddar, etc.); yogurt; ice cream or ice milk; and pudding. A serving is equivalent to 8 oz. of fluid milk and provides at least 250 mg. of calcium. All milk shall be pasteurized and fortified with Vitamins A and D. The daily requirement is three servings. For persons 15-17 years of age, or pregnant and lactating women, the requirement is four servings. One serving can be from a calcium-fortified food containing at least 250 mg. of calcium.

From the Dairy Group of this regulation, inmates must receive at least 24 ounces of milk or milk equivalents daily, (three servings). Examples of milk equivalents include soy, or a similar product if it meets the nutritional standards of calcium, and Vitamins A and D. There are other products that include calcium and Vitamins A and D, (fortified fruit juices, breads, cereals, etc.).

One serving equals, but is not limited to, the following examples:

8 oz. fluid milk (nonfat, 1% or 2% reduced fat)	1½ oz. natural cheese
2 oz. processed cheese	1½ cups nonfat or low fat cottage cheese
1½ cups ice cream or ice milk	1/3 cup nonfat dry milk
½ cup nonfat or low fat evaporated milk	1 cup nonfat or low fat plain yogurt
1 cup pudding	

Subsection (c) addresses the Vegetable-Fruit Group and includes fresh, frozen, dried and canned vegetables and fruits. One serving equals: 1/2 cup vegetable or fruit; 6 ounces of 100% juice; 1 medium apple, orange, banana, or potato; 1/2 grapefruit; or 1/4 cup dried fruit. The daily requirement of fruits and vegetables shall be five servings. At least one serving shall be from each of the following three categories:

1 One serving of a fresh fruit or vegetable.
2. One serving of a Vitamin C source containing 30 mg. or more.

One serving equals, but is not limited to, the following examples:

Broccoli	Brussels Sprouts
Cabbage	Cantaloupe or honeydew melon
Cauliflower	Grapefruit
Grapefruit juice	Green and red peppers (not dehydrated)
Greens, including collards, kale, turnip and mustard greens	Orange
Orange juice	Potatoes (baked only)
Strawberries	Tangerine, large
Tomato juice	Tomato paste
Tomato puree	Tomato sauce (6 oz.)
Vegetable juice cocktail	

2. One serving of a Vitamin A source, fruit or vegetable, containing 200 micrograms Retinol Equivalents (RE) or more. One serving equals, but it not limited to, the following examples:

Apricot nectar (6 oz.)	Apricots
Cantaloupe	Carrots
Greens, including kale, beets, chard, mustard greens, turnips or spinach	Mixed vegetables with carrots (frozen)
Peas and carrots	Pumpkin
Red peppers	Sweet potatoes or yams
Vegetable juice cocktail (6 oz.)	Winter squash

Subsection (d) addresses the Grain Group and includes bread, rolls, pancakes, sweet rolls, ready-to-eat cereals, cooked cereals, corn bread, pasta, rice, tortillas, etc. and any food item containing whole or enriched grains. At least three servings from this group must be made with some whole grains. The daily requirements shall be a minimum of six servings.

One serving equals, but is not limited to, the following examples:

White (including French and Italian), whole wheat, rye, pumpernickel, or raisin bread	1 slice
Bagel, small	½ slice
English muffin, small	½ slice
Plain roll, muffin or biscuit	1 slice
Frankfurter roll	½ slice
Hamburger bun	½ slice
Dry breadcrumbs	3 Tbsp.
Graham crackers (2½")	2 crackers
Matzo crackers (4"x6")	½ cracker
Oyster crackers	20 crackers
Pretzels (3 1/8" long, 1/8" dia.)	25 pretzels
Rye wafers (2"x3½")	3 wafers
Soda crackers (2½" square)	6 crackers
Ready to eat unsweetened cereal	3/4 cup
Cereal (cooked), rice, barley, couscous, grits, pastas, spaghetti, macaroni, noodles, etc.	½ cup
Flour (wheat, whole wheat, carob, soybean, cornmeal, etc.)	2½ Tbsp.
Wheat germ	¼ cup
Pancakes (5")	1 pancake
Waffle (5")	1 waffle
Tortilla (6")	1 tortilla

The following grains meet the partial or whole grain requirement:

Barley	Bran
Brown rice	Carob flour
Corn meal (germed)	Cracked wheat
Rolled oats	Rye
Soybean flour	Whole wheat flour

The following bread-cereal products meet the partial or whole grain requirement:

Corn tortilla	Grits
Oatmeal	Pumpernickel bread
Whole grain bagels, muffins, and crackers	Whole grain hot cereal
Whole grain pancakes and waffles	Whole grain ready-to-eat cereal
Whole wheat bread	Whole wheat flour tortilla
Whole wheat rolls	

Several nutrient standards have changed in the DRIs. This regulation reflects the changes that pertain to the specific nutrients that are monitored in correctional facilities. For example, the calcium requirement for males and females has increased; therefore, the number of servings in the dairy group has increased from two to three servings.

The manner in which caloric requirements are calculated has also changed. The DRIs do not have a chart that lists the caloric requirements based on gender and age as outlined in the previous RDAs. The DRIs refer to the caloric requirements as indicated in the Estimated Energy Requirements and is defined as the dietary energy intake that is expected to maintain energy balance (or weight) in healthy, normal weight individuals of a defined age, gender, weight, height, and level of physical activity consistent with good health. The DRIs also utilize the Body Mass Index (BMI).

For example, a sedentary, 30 year old, 5'11" male who weighs 178 pounds (BMI 24.99 kg/m^2) can consume 2,635 calories to maintain weight. A male with the same age, height, and weight, but has a low activity level can consume approximately 250 more calories per day. The same male who is active can consume 500-600 more calories per day to maintain weight. For instance, if a facility has a work furlough program, participating inmates would require additional calories because they are more active than the general inmate population.

A sedentary, 30 year old, 5'5" female who weighs between 111 and 150 pound (BMI between 18.5 and 24.99 kg/m2) can consume 1,800 to 2,000 calories to maintain weight. However, if this same female had a low activity level, approximately 200 additional calories per day can be consumed to maintain weight. It is important that the Registered Dietitian associated with your facility determine the appropriate caloric range for the inmate population of your facility and whether the menu is calorically adequate. Further details regarding the DRIs can be obtained at http://www.nap.edu/ or through the American Dietetic Association at http://www.eatright.org/ by requesting a copy of the **November 2002 Journal of American Dietetic Association article, "Dietary Reference Intakes for Energy, Carbohydrate, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids."**

Local health officials reviewing the nutritional content of facility menus and/or conducting the nutrition portion of the Title 15 inspection must have a familiarity with the DRIs. Some of the nutrient requirements that appear in the DRIs are calculated over a seven day period, yet are listed as a daily requirement. Because of the way the DRIs are calculated, it is appropriate for menu evaluators and inspectors to evaluate the entire weeks' menu, rather than determining that a single meal or day is out of compliance with the daily requirement. For example, when evaluating the menu for compliance with the Vitamin A requirement, the evaluator would

calculate seven total servings for the week for Vitamin A. This would address those circumstances where one day of the week, there were no servings of Vitamin A, but on the following day, there were two servings. Since there were a total of seven servings for a whole week, the menu for this week would be considered compliant with the Vitamin A requirement. A nutritional analysis would be beneficial to food services managers when assessing the caloric and nutrient adequacy of the daily and weekly menu.

This regulation reflects a 30% limitation on calories from fat, in keeping with chronic disease prevention goals. With the limitation of calories from fat, emphasis should be given to other food sources to achieve the required energy values.

Meal planners should work closely with facility staff to improve diets. Food is a morale issue in facilities and often a high point in the day for the inmates. Eye appeal and to some extent, presentation can impact its acceptance as well as the content and flavor of the meals themselves. Acceptance is an important factor, as food that is not accepted by the inmates tends to be discarded. (Factors such as greasy trays can have an adverse effect on acceptance). Fresh fruit that might otherwise be discarded may be more acceptable if incorporated into recipes. The absence of candy and sweets will enhance the acceptability of fresh fruit, either as a portion of the meal or as a snack.

To ensure continual improvement, it is important for staff to share information regarding food-related grievances and food waste with food services managers. When planning the menu, facility and food service managers should take into consideration the costs associated to the number of food related complaints and the amount of food being discarded.

Good nutrition enhances health and this is particularly important for inmates with a history of abusing alcohol and drugs. Many have neglected their nutrition to the point that they have any of a variety of health conditions that can be stabilized with a good diet. A healthy diet may actually be cost effective, if compared to the associated health care costs if not addressed. As the diet examples show, good nutrition need not be expensive. For example, fatty processed meats are expensive and can be dramatically reduced or eliminated, by following the United States Department of Agriculture (USDA) and other health conscious scientific groups recommendation for consumption of at least five servings of fruits and vegetables daily.

Cost savings can also be realized through better food choices. Reducing or eliminating cakes, pies, cookies, and puddings in favor of in seasonal fresh fruit, is both cost effective and recommended by dietitians and health care professionals. However, because of the potential that they will be used to produce contraband, it is important to discuss their addition into the menu with the facility manager.

Vegetarian and religious diets are considered elective; there is no regulatory requirement that they be provided. However, some jurisdictions have made accommodations in this area and the regulations include textured vegetable protein (TVP) as an alternative protein source. If a facility chooses to allow this option, they are required to meet the dietary regulations set forth in this section.

This regulation requires temporary holding facilities to provide the full DRI; however, determining what constitutes a full DRI presents a problem to facility managers and inspectors. Most inmates in these facilities are in custody for a few hours with time only for one or two meals. The problem is determining an acceptable nutritional value for any one meal. In this instance, the intent of the regulation is best described as requiring the arresting agency to provide reasonably nutritious meals in their feeding program. The inspector must take the facility operation into account and use good judgment when analyzing the food service. Typically, these facilities have frozen dinners in stock or obtain food from a local restaurant when needed. Both of these options are reasonable. Temporary holding facilities are still expected to comply with the frequency of serving as described in **Section 1240, Frequency of Serving.**

Court holding facilities are not regulated by **Sections 1240, Frequency of Serving** or **1241, Minimum Diet.** Many, if not all, of the meals served to the inmates held in court holding facilities are provided by facilities that are regulated. These facilities also must maintain the food in a safe manner and deliver the meals under staff supervision **Section 1246, Food Serving).**

If Type IV facilities serve three meals a day to their inmates, they are required to provide the full minimum diet. If they do not, assessing their food services program will require flexibility and good judgment, as one will not be able to determine the nutritional value of meals that are obtained outside the facility.

See **Appendix 9** for sources of Vitamins A and C from the 18th edition of **Bowes and Church Food Values of Portions Commonly Used, New York, Lippincott-Raven Publishers, 2005.** Regulation references to Vitamin A were changed to reflect Retinol Equivalents (RE) from International Units(IU). Retinol Equivalents are a more commonly used unit of measure from a plant source, (2000 IU = 200 micrograms RE).

1242. Menus.

Menus in Type II and III facilities, and those Type IV facilities where food is served, shall be planned at least one month in advance of their use. Menus shall be planned to provide a variety of foods, thus preventing repetitive meals. Menus shall be approved by a registered dietitian before being used.

If any meal served varies from the planned menu, the change shall be noted in writing on the menu and/or production sheet.

Menus, as planned, and including changes, shall be evaluated by a registered dietitian at least annually.

Guideline: This regulation applies to Type II and III facilities, and those Type IV facilities where food is served, and includes those facilities where the kitchen is located off-site. Menus must be planned at least one month in advance of their use. A registered dietitian must approve these menus before they are used. A sample menu planning worksheet is provided in **Appendix 10.**

There is no requirement for Type I facilities to plan menus in advance; however, when a Type I facility houses sentenced inmate workers, attention should be given to rotating their menus to

provide variation in the diet. (One method for motivating inmates to work is to provide good food.) It would be useful for Type I facilities to plan menus in advance and keep copies of their menus for the annual health inspections. In addition to avoiding repetition and ensuring balanced and nutritious meals, such information, i.e., a planning cycle, contains information that can be helpful. For example, a facility manager would have access to information regarding the cost and quantities of purchased goods to determine whether purchasing in bulk would be more cost effective.

There are many prepared and convenience foods that might be used to effectively save time and money. The modern institutional menu should reflect both traditional items and convenience foods in a reasonable combination, with choices being guided by cost-per-serving, preparation time and acceptance by inmates.

In order to plan meals the facility can readily prepare and serve, the person preparing menus should be aware of the kitchen's capabilities, e.g., baking ovens, soup vats, utensils, food serving plans, etc. Sometimes this is not possible, and in these instances, the nutritionist or dietitian should consult with kitchen staff and serving personnel. They should also reinforce to kitchen staff the importance of noting and saving any changes from the planned and approved men until evaluated by the registered dietitian. Archived menus are an excellent resource for budget development, menu cycle planning, and training. They also are invaluable documentation in the event of litigation.

It is the facility manager's responsibility to ensure that a registered dietitian has completed an annual evaluation of the facility's menus. While not required by this regulation, optimally, this evaluation would include an on-site visit by a professional that is independent from the department, such as a public health nutritionist or a hospital dietitian. In this case, the evaluation should include sampling a line meal. However, an evaluation can be accomplished by mailing copies of the menus to a dietitian. After completing the review, the dietitian should send an evaluation to the originating facility. Whether conducted on-site or through the mail, every effort should be made to ensure the evaluated menus reflect the meals that were served. If deficiencies are identified, they should be corrected as soon as possible.

The dietitian's review should be kept on file at the facility, used as a tool to evaluate food services, and be available for review during the annual **Title 15** inspection.

1243. Food Service Plan.

Facilities shall have a written food service plan that shall comply with the applicable California Uniform Retail Food Facilities Law (CURFFL). In facilities with an average daily population of 100 or more, there shall be employed or available, a trained and experienced food services manager to prepare and implement a food service plan. In facilities of less than an average daily population of 100 that do not employ or have a food services manager available, the facility administrator shall prepare a food service plan. The plan shall include, but not limited to, the following policies and procedures:
( ) menu planning;
( ) purchasing;
( ) storage and inventory control;

( ) food preparation;
( ) food serving;
( ) transporting food;
( ) orientation and ongoing training;
( ) personnel supervision;
( ) budgets and food cost accounting;
( ) documentation and record keeping;
( ) emergency feeding plan;
( ) waste management; and
( ) maintenance and repair.

Guideline: This regulation has several components. First, it requires that all facilities have a food service plan and identify who is responsible for its development. The intent is to provide the food services manager or facility administrator the latitude to develop a plan that meets the needs of the facility. Consequently, the regulation avoids prescriptive language. It serves as a guide by listing the scope of responsibilities that should be included in the food service plan.

In facilities with an ADP of 100 or more, there must be a trained and experienced food services manager employed or available to prepare and implement a food service plan. In facilities with an ADP of less than 100 where a food services manager is not employed or available, the facility administrator is responsible for preparing and implementing the food service plan. While not all elements of this regulation may be applicable to smaller facilities, the plan should clearly address those elements that are applicable. When elements of this regulation are not applicable to a facility, they should be noted, and the reasons why an element is not applicable should be documented. This will help avoid any confusion during the annual nutrition inspection.

Food service managers should be trained and experienced in the areas set out in this section. There is no licensing requirement. The manager is responsible for ensuring that kitchen personnel are adequately supervised, but allows this activity to be delegated. In smaller systems, the manager may be responsible for daily operations; in larger systems, staff performance will be delegated. The written plan and its implementation is the responsibility of the food service manager. Addressing each of the elements listed in the regulation should result in a plan that is comprehensive, resulting in a description of all the responsibilities and activities of the food services manager.

Second, the plan should include meals that are nutritionally balanced, palatable, seasonable, presentable, and cost effective. The food services manager should be cognizant of how the food is served to and received by the inmates. To accomplish this the manager should randomly observe inmates when food is being served, monitor what food(s) are not eaten, solicit feedback from custody staff and inmates, review food grievances from inmates and other such activities.

Third, it should include an annual budget; identify food costs, and include an inventory system. It should be organized, have written food specifications (including formal bids) and list current and potential vendors. It should address cost effectiveness by implementing a portion control system that is aided by trained staff using standardized recipes and ensuring appropriate serving amounts.

Fourth, it should address transporting meals, serving logistics, and meal scheduling procedures. There should be a procedure for routine, documented inspections of food, equipment, and food service operations. The procedures should include documented temperature checks of food, refrigerators, freezers, etc. Its intent is to have safe and efficient operation. It should address security issues, such as knives, and other sharp objects; and include the location of stored but seldom used equipment such as ice chests.

The manager should identify pertinent training topics relative to food service staff, including custody staff and inmates. Critical components include safe food handling techniques, proper temperatures, personal hygiene, cleanliness, sanitation, etc. Other examples of training include: emergency preparedness, safety and security, proper lifting techniques, and other work related training.

The food services manager should work closely with the facility administrator and manager when developing emergency feeding plans. It should include procedures or provisions for emergencies.

The following examples reference the subsections of the regulations.

( ) menu planning: cycle menus; seasonal menus; nutritional analysis; menu distribution; production worksheet; snacks; supplemental food, and dietary adjustments, e.g., therapeutic, religious, and vegetarian.

( ) purchasing: specifications; quote/bid process; identifying vendors; delivery; schedules; billing process; nutritional fact sheets; payment expectations, and ordering procedure.

( ) storage and inventory control: receiving procedures; rotation; label and date; opened case policy; cycle menu usage; usage documentation, and unused portion procedure.

( ) food preparation: cook/chill or serve; bakery; prep room; on-site preparation, and standardized recipes.

( ) food serving: safe and sanitary manner; portion control; set-up line; clean up; ServSafe (a CURFFL trademark safety program); supervision, and time meal schedule.

( ) transporting food: bulking; hot/cold food; supplemental food; disaster food, and dietary adjustment.

(f) orientation and on-going training: dress code; timecard procedure; sick slips; job standards; expectations; job advancement/career ladder; training schedule; chain-of-command; continuing on-the-job training, and training of food service staff, custody staff, and inmates.

(f) personnel supervision: place of employment; times; check-in procedures; site requirements, and sick call/vacation requests.

(f) budgets and food costs accounting: food costs; salary costs; non-food costs; indirect costs; costs per serving; meal cost, and revenue.

(f) documentation and record keeping: inventory and location of equipment, e.g., number of knives and where stored, location of seldom used items (ice chests); incident reports; report writing; on-site forms, and HACCP documentation.

(f) emergency feeding plan: lock-down; disaster, and disruption.

(f) waste management: recycling, garbage disposal, and hazardous material.

(f) maintenance and repair: inventory of equipment, vendor and repair contacts, and regular and routine documented inspection of facilities and equipment.

Food service and facility managers should consider using the various forms designed for Title 15 annual inspections as a guide to writing policies and procedures related to food services. These forms can also be useful for conducting self-audits or conducting quality improvement studies.

1245. Kitchen Facilities, Sanitation, and Food Storage.

(a) **Kitchen facilities, sanitation, and food preparation, service, and storage shall comply with standards set forth in Health and Safety Code, Division 104, Part 7, Chapter 4, Articles 1-8, Sections 113700 et seq. California Uniform Retail Food Facilities Law (CURFFL).**

(a) In facilities where inmates prepare meals for self-consumption or where frozen meals or pre-prepared food from other permitted food facilities (see Health and Safety Code Section 113920) are (re)heated and served, the following applicable CURFFL standards may be waived by the local health officer:

(0) H & S Section 114065;

(0) H & S Section 114090(b) and (e), if a domestic or commercial dishwasher capable of providing heat to the surface of the utensils of a temperature of at least 165 degrees Fahrenheit, is used for the purpose of cleaning and sanitizing multi-service utensils and multi-service consumer utensils;

(0) H & S Section 114140 except that, regardless of such a waiver, the facility shall provide mechanical ventilation sufficient to remove gases, odors, steam, heat, grease, vapors and smoke from the kitchen;

(0) H & S Section 114150(a); and,

(0) H & S Section 114165(b).

Guideline: The **California Uniform Retail Food Facilities Law** (**CURFFL**) in the **HSC** is an important resource to facility administrators and food managers. In addition to the **CURFFL** sections listed in the regulation, the following **CURFFL** sections are also important:

Section 113725 gives primary responsibility for enforcement to the State Department of Health Services, which acts through local health agencies.

Section 113780 defines a food establishment as "…any room, building, or place, or portion thereof, ...used, or operated for the purpose of storing, preparing, serving, manufacturing, packaging, transporting, salvaging or otherwise handling food..."

Section 113880 defines a satellite food distribution facility as "A location where only prepackaged, unit servings of food are distributed, that have been prepared or stored in an approved food facility operated by a school, governmental agency, or nonprofit organization."

Section 113903 defines a vending machine and thereby addresses facilities that use vending machines for delivery of foods other than snacks (e.g., candy, cookies, crackers, beverages, etc.).

Section 113920 requires a valid permit, issued by the local enforcement agency pursuant to an investigation, for any food facility to operate.

Section 113925 allows any enforcement officer to enter, inspect, issue citations and secure any sample...or other evidence from any food facility...for the purposes of enforcing this chapter.

Section 113935 makes it a misdemeanor to violate any of these provisions.

Section 113950 allows health officers to suspend permits and close food facilities which do not comply.

Article 7, Sections 113990 -114070 describe the sanitation requirements for food facilities.

Article 8, Sections 114075 -114180 describe the sanitation requirements for food establishments.

Among other things, **CURFFL** requirements and good judgment permit the use of single-service, disposable paper and plastic utensils and flatware, particularly for inmates who are ill with communicable diseases and inmates who are in administrative segregation or disciplinary isolation and are likely to abuse normal service ware. Single service items should be used only once.

Please note that **Subsection (b)** relates to food "from permitted food facilities;" this refers to food service facilities that have a food service permit pursuant to **CURFFL** and are thereby subject to inspection by the Department of Health Services.

This regulation permits some detention facilities to have less than a full commercial kitchen and provides enhanced flexibility for food service area design and operation while maintaining all necessary and relevant health and safety regulations. This regulation was developed primarily to acknowledge situations where inmates cook for themselves, as in some Type IV facilities where there are apartment units with kitchens. It was broadened somewhat to benefit some city jails where food was prepared for self-consumption or provided in the form of frozen meals and was reheated. While facilities may be eligible to have a kitchen with reduced features, this cannot occur unless, and until, the local health officer reviews the request and specifically identifies which of the **CURFFL** regulations listed in this regulation may be waived. Facility managers should also be aware that if they are granted waivers from identified **CURFFL** requirements, and thereafter change their feeding program, they might be required to modify their kitchen to more closely conform to **CURFFL** requirements.

Facility cooking staff needs to be aware of the cooking temperature requirements adopted by AB 396, Kaloogian, known as the **Lauren Beth Rudolph Food Safety Act of 1997 (HSC Section 113996)**. This law affects the cooking temperature requirements for: meat; comminuted meat; egg and food containing war eggs; and, poultry.

1246. Food Serving and Supervision.

Policies and procedures shall be developed and implemented to ensure that appropriate work assignments are made and food handlers are adequately supervised. Food shall be prepared and served only under the immediate supervision of a staff member.

Guideline: This regulation requires that policies and procedures be developed to ensure that food handler work assignments are identified and that food handlers are supervised. This is to ensure that appropriate work assignments are made, that food handlers are adequately supervised, and that food is prepared and served under the immediate supervision of a staff member. This will also ensure that each item on the menu is served, proper utensils are used to serve equal portions of food, and that proper food temperatures are maintained.

For public health reasons, **CURFFL** requires that food be kept hot (135 degrees Fahrenheit or above) or cold (41 degrees Fahrenheit or below), as appropriate, until it reaches the inmate. If the kitchen is located some distance from the dining area, food should be transported in insulated, heated or cooled food carts, or other containers. They may be loaded with pre-served trays or with bulk food containers and all necessary utensils, and then taken directly to the dining area. To protect from contamination and to maintain safe temperatures, food transported on serving plates or containers should be covered and served as rapidly as possible.

Food must be served under the immediate supervision of a staff member to ensure that fair and equal portions are given to each inmate in a sanitary manner. Some jurisdictions report adulteration of food served to gang rivals and enemies of kitchen workers, as well as providing extra portions of desirable food items to their friends and allies. Inmates should be required to finish their meals in the dining area and not be allowed to store food in their living quarters. Besides being unsanitary, such storage encourages pilfering, brings disciplinary problems, and invites vermin in the living quarters.

It is imperative that staff understand: food time and temperature requirements; the health and safety risks that exist with food that reaches "dangerous" temperature levels; and their responsibility to notify food services staff when the temperature has not been maintained. When the temperature of food/meals falls within a specified range (for a specified period of time) it can promote food-borne illnesses. Although the regulation does not specifically discuss basic food safety training/instruction, it is critical that staff understand that meals are maintained at the proper temperatures until served to the inmates. The food services plan should require staff to provide a substitute (nutritious and safe) meal to inmates when the time and temperature of the regular meal falls outside acceptable limits

1247. Disciplinary Isolation Diet.

( ) A disciplinary isolation diet which is nutritionally balanced may be served to an inmate. No inmate receiving a prescribed medical diet is to be placed on a disciplinary isolation diet without review by the responsible physician or pursuant to a written plan approved by the physician. Such a diet shall be served twice in each 24 hour period and shall consist of one-half of the loaf (or a minimum of 19 oz. cooked loaf) described below or other equally nutritious diet, along with two slices of whole wheat bread and at least one quart of drinking water if the cell does not have a water supply. The use of a disciplinary isolation diet shall constitute an exception to the three-meal-a-day standard. Should a facility administrator wish to provide an alternate disciplinary diet, such a diet shall be submitted to the Board of Corrections for approval.

( ) The disciplinary diet loaf shall consist of the following:

2-1/2 oz. nonfat dry milk
4-1/2 oz. raw grated potato
3 oz. raw carrots, chopped or grated fine
1-1/2 oz. tomato juice or puree
4-1/2 oz. raw cabbage, chopped fine
7 oz. lean ground beef, turkey or rehydrated, canned, or frozen Textured Vegetable Protein (TVP)
2-1/2 fl. oz. oil
1-1/2 oz. whole wheat flour
1/4 tsp. salt
4 tsp. raw onion, chopped
1 egg
6 oz. dry red beans, pre-cooked before baking (or 16 oz. canned or cooked red kidney beans)
4 tsp. chili powder

Shape into a loaf and bake at 350-375 degrees for 50-70 minutes.

Guideline: Regulations require that food will not be withheld from an inmate as a disciplinary measure for major infractions **(Section 1083, Limitations on Disciplinary Actions).** With respect to inmates who are on a prescribed medical diet, the responsible physician must be consulted prior to putting that inmate on the disciplinary isolation diet. This is to assure that the disciplinary diet does not result in any unanticipated health consequences. The regulation includes a meat substitute and the vegetarian disciplinary option can also be used for a lactose-free disciplinary diet. Both the meat and the vegetarian options for the disciplinary isolation diet meet the nutritional requirements of **Section 1241, Minimum Diet**. A nutritional analysis of the diet is available upon request to the Board of Corrections. This recipe was updated to comply with the new DRI requirements and the carrot portion has been changed from 4 ½ oz. to 3 oz. of Carrots.

The 72- hour limitation was moved to **Section 1083, Limitations on Disciplinary Actions**, because restrictions on the use of the dis ciplinary diet are a custody issue.

1248. Medical Diets.

The responsible physician, in consultation with the facility administrator, shall develop written policies and procedures that identify the individual(s) who are authorized to prescribe a medical diet. The medical diets utilized by a facility shall be planned, prepared and served with consultation from a registered dietitian. The facility manager shall comply with any medical diet prescribed for an inmate.

The facility manager and responsible physician shall ensure that the medical diet manual, which includes sample menus of medical diets, shall be available in both the medical unit and the food service office for reference and information. A registered dietitian shall review, and the responsible physician shall approve, the diet manual on an annual basis.

Guideline: This regulation requires the provision of medical diets when prescribed. The most common diets are diabetic, renal and cardiac. Others should be considered if the facility has

historically housed medically fragile inmates. Medical diets should be incorporated into a manual developed by a dietitian, and approved by the responsible physician.

One approach to developing the diet is for the responsible physician, health authority, on-site food service manager and a dietitian to work as a team to develop a list of diets that should be readily available. The team would also develop a plan for meeting any special dietary needs that cannot be addressed in the facility. The team should establish in writing who has the authority to order a medical diet (e.g., a registered nurse) and how the kitchen will ensure an inmate receives the proper diet.

The dietitian and food service manager should develop the actual menu substitution lists, and develop procedures. The diets and procedures must be reviewed annually to ensure they are clinically current and reflect actual facility practices.

The menus for implementing medical diets need to be written in a manner that is sufficiently flexible and practical to allow food service staff to meet the requirements with available resources. While it may be necessary to make substitutions in a given menu, it is important that the diet manual provides sufficient guidance to assure that substituted items are permissible. It is not acceptable to leave kitchen staff, under the duress of time constraints to produce a meal, to use their own judgment in modifying medical diet menus. Each facility that houses inmates who require medical diets must ensure that current sample menus and acceptable substitutions are included in the medical diet manual. With respect to females who are known to be pregnant, the responsible physician should consider having a policy that permits routine initiation of a pregnancy diet, even prior to a medical evaluation.

The importance of having facility policy and procedures in place to ensure medical diets are delivered to the intended inmate cannot be over emphasized. It is critical that the medically prescribed diets are actually delivered to the designated inmate. To accomplish this, the individuals involved in the development, planning, preparation and delivery of these meals must work closely together. Food service staff must be notified when inmates receiving medical diets are transferred (inter- and intra-facility) and/or released from custody (either temporarily or permanently).

Even the most careful advance planning cannot anticipate all possible medical diet needs. In recognition of this, each facility should identify a resource to contact for assistance whenever the need arises for an unusual medical diet.

ARTICLE 13. INMATE CLOTHING AND PERSONAL HYGIENE

1260. Standard Institutional Clothing.

The standard issue of climatically suitable clothing to inmates held after arraignment in all but Court Holding, Temporary Holding and Type IV facilities shall include, but not be limited to:

- **( ) clean socks and footwear;**
- **( ) clean outergarments; and,**
- **( ) clean undergarments;**

(0) for males -- shorts and undershirt, and,

(0) for females -- bra and two pairs of panties.

The inmates' personal undergarments and footwear may be substituted for the institutional undergarments and footwear specified in this regulation. This option notwithstanding, the facility has the primary responsibility to provide the personal undergarments and footwear.

Clothing shall be reasonably fitted, durable, easily laundered and repaired.

Guideline: At the discretion of the facility administrator, inmates may be allowed to wear their own clothing as long as the clothing is clean and appropriate. Whether clothing is the inmate's own or standard issue, it should be easily recognizable as jail clothing, to distinguish inmates from staff and visitors. Clothing should be in keeping with the norms of the community and may be constructed of inexpensive but serviceable materials, easily washed and dried and adequate for seasonal comfort, health and protection. The facility manager has the primary responsibility to provide personal undergarments and footwear, and cannot compel the inmate to supply such items. Where personal clothing is allowed, the manager will face the problem of providing resources to allow the clothing to be properly laundered on a regularly scheduled basis, and should orient the inmates to that policy and procedure.

Clothing issue, if it is the facility's policy to issue clothing, must occur at the time of booking, after arraignment, or when it becomes apparent that an inmate will remain in the facility for more than 96 hours excluding holidays. Most typically, inmates are issued clothing following booking or after arraignment. The standard issue of institutional clothing includes two pairs of panties for female inmates. While this may pose a logistical problem for some large jails, it has been deemed important for health and sanitation reasons.

Sandals or sneakers are practical footwear and they are inexpensive and washable. Inmates working specialized jobs in or outside the facility should wear shoes or boots appropriate for their work assignment. Shoes or boots issued to inmates must be cleaned, or minimally receive a thorough dusting with foot powder or some type of fungicide, between uses. Facility managers may wish to consult with their health authority regarding methods of sanitizing footwear.

In facilities that do not regularly issue institutional clothing, there should be a plan to provide emergency clothing to inmates who need them. Examples of circumstances that might necessitate issuing emergency clothing include: vermin infested clothing taken from an arrestee coming into the facility; destroyed or badly soiled clothing; or inappropriate clothing (e.g., a bathing suit, etc.).

1261. Special Clothing.

Provision shall be made to issue suitable additional clothing, essential for inmates to perform such special work assignments as food service, medical, farm, sanitation, mechanical, and other specified work.

Guideline: Specialized clothing or personal protective clothing (e.g., gloves, shoes or boots) is frequently required for inmates performing work assignments in, around, or outside a facility. In certain work assignments, specialized clothing is considered essential to provide for the inmate's

safety and security, as well as the inmate's hygiene and facility's sanitation. Special clothing must be suited to the type of work and climatic conditions that exist at the work place. A written plan for providing special or safety clothing should be developed. Knowingly assigning inmates to jobs that expose them to some risk without the necessary clothing, equipment or training unnecessarily exposes the facility to liability and does not adequately protect the inmate.

1262. Clothing Exchange.

There shall be written policies and procedures developed by the facility administrator for the scheduled exchange of clothing. Unless work, climatic conditions, illness, or California Uniform Retail Food Facilities Law, necessitates more frequent exchange, outergarments, except footwear, shall be exchanged at least once each week. Undergarments and socks shall be exchanged twice each week.

Guideline: All clothing must be issued clean, freshly laundered, in good repair and free of vermin. Pants, shirts, etc. must be exchanged at least once a week; with undergarments and socks exchanged at least twice each week. More frequent exchanges may be necessary depending on work, climatic conditions, illness, or **CURFFL (HSC Section 114020)**. Facility managers should consider discarding undergarments when they become heavily stained due to the effect it might have on morale. Managers have reported that inmates have refused to wear stained undergarments, although clean, due to their disturbing appearance.

Where inmates are permitted to wear their own clothing, there must be policy and procedures for laundering and/or repairing those clothes on a regular and as needed basis.

The question of whether or not to operate a laundry in the facility is addressed in the facility's planning and design phase and is subject to the needs assessment and program statement required by **Title 24, Sections 13-102 (c) 2 and 3**. It may be more economical to use a private vendor or another nearby institutional laundry; however, if the administration plans to operate or add a laundry, space must be allocated for the following:

0. soiled clothing storage;
0. washer, extractor, dryer;
0. clean laundry storage; and,
0. laundry supplies (soaps, bleaches, etc.) storage.

All of these basic elements are essential regardless of the size of the laundry. In addition, attention must be paid to the movement of clean and soiled laundry through the facility. Failure to take into consideration the movement and storage of laundry, as well as the location of the laundry itself, can severely impact facility operations. This may be a special problem in high-rise facilities as it increases demand for elevator usage.

Dry cleaning equipment or a contract with a qualified private vendor may be considered to clean inmate's personal clothing before it is stored and/or to clean blankets and other non-washable items. The decision to do dry cleaning is optional for detention facilities and carries with it other considerations and issues.

1263. Clothing Supply.

There shall be a quantity of clothing, bedding, and linen available for actual and replacement needs of the inmate population.

Written policy and procedures shall specify special handling of laundry that is known or suspected to be contaminated with infectious material.

Guideline: There should be a regular review of the inventory of clothing to determine that there are an adequate number of items in the proper range of sizes to meet the clothing exchange requirements described in **Section 1262, Clothing Exchange**. Each facility must have a written procedure for: purchasing; handling, storage; transportation; and processing of clothing, bedding and linen. The intent is to assure that an appropriate clean supply is on hand at all times.

An adequate supply of clothing, bedding and linen will differ from one facility to another. A number of variables effect this, not the least of which is whether the facility does laundry on-site or sends it out. Handling or transportation delays might occur if clothing and linen is laundered at a remote facility; thus, a larger inventory may be necessary than if the facility does laundry on the premises. It might be more costly to do laundry on-site, given equipment, space and energy costs. These decisions can become complex, so facility administrators may want to consult with experts relative to making decisions about laundry facilities.

Laundry procedures must also take into account contamination with potentially infectious materials, such as blood, feces, wound drainage, and other substances. This might be evident as visible soiling, or it may not be apparent to the naked eye. In either case, procedures need to provide for either adequate decontamination through appropriate laundering techniques or disposal. The safety of staff and inmates must be addressed.

While it is a good idea to adopt procedures that assume contamination of all linen and clothing (analogous to applying "standard precautions" in the case of body fluids), this regulation is specifically applicable to a more narrow range of circumstances. At minimum, facilities need to address handling linens which become contaminated with large quantities of body substances (e.g., blood, amniotic fluid, etc.), as well as linens used by an inmate who has been placed in isolation for an infectious disease for which special handling of linens is recommended (e.g., Hepatitis A). The former situation is likely to occur anywhere in the facility as the result of an emergency, whereas the latter is likely to be associated with designated health care housing. In either case, all staff needs to be aware of how to handle contaminated articles.

Procedures need to include methods for the separate collection and labeling of contaminated laundry. Special laundry bags for this purpose may be purchased for convenience. Precautions to safeguard inmate workers should include protective gloves and handling methods that minimize the possibility of contact with suspected contaminated materials. While proper laundering techniques are highly effective in sanitizing contaminated linens and clothing, it is essential to assure that practices are actually carried out as specified in procedure. This would include proper measurement of detergents and other additives, as well as assuring that cycle lengths and temperatures for hot water washing and drying are achieved. In cases where gross saturation or contamination is sufficient to justify disposal, procedures need to be in place for

proper handling as medical waste. Local environmental health departments can serve as a resource to jail administrators for establishing policy and practice.

1264. Control of Vermin in Inmates Personal Clothing.

There shall be written policies and procedures developed by the facility administrator to control the contamination and/or spread of vermin in all inmates personal clothing. Infested clothing shall be cleaned, disinfected, or stored in a closed container so as to eradicate or stop the spread of the vermin.

Guideline: The policy and procedures required by this section should be developed in consultation with the responsible physician, and should reference and include medical protocols for the treatment of infested clothing. Note that this regulation allows the facility manager the option of cleaning, disinfecting or storing infested clothing. The third option of securing the clothing in a sealed container might be achieved by simply placing the articles in a plastic bag and taping it shut; however, conditions can exist that allow for damp clothing to mildew. Implement procedures that ensure infestations of lice, mites and other vermin do not enter the facility on inmate clothing that is improperly cleaned or stored. The local health department is a resource available to help develop to facility managers.

If inmates wear personal clothing to court, and then return it to the institution for re-storage, the facility will need to decide whether or not to clean that clothing each time it is worn. Some facilities allow inmates' families to have a role in providing clean clothing for court appearances. Security issues notwithstanding, these regulations do not preclude this practice.

Please see **Section 1212, Vermin Control, Section 1206.5 Management of Communicable Diseases in a Custody Setting**, and **Section 1280, Facility Sanitation, Safety, and Maintenance** and **Appendix 11, Lice and Scabies Control** for further discussion of issues related to this regulation.

1265. Issue of Personal Care Items.

There shall be written policies and procedures developed by the facility administrator for the issue of personal hygiene items. Each female inmate shall be issued sanitary napkins and/or tampons as needed. Each inmate to be held over 24 hours who is unable to supply himself/herself with the following personal care items, because of either indigency or the absence of an inmate canteen, shall be issued:

(a) toothbrush,
(b) dentifrice,
(c) soap,
(d) comb, and
(e) shaving implements.

Inmates shall not be required to share any personal care items listed in items "a" through "d." Inmates will not share disposable razors. Double edged safety razors, electric razors, and other shaving instruments capable of breaking the skin, when shared among inmates, must be disinfected between individual uses by the method prescribed by

the State Board of Barbering and Cosmetology in Sections 979 and 980, Division 9, Title 16, California Code of Regulations.

Guideline: The policy and procedures called for by this regulation should outline how inmates are made aware that personal care items are available on an as-needed basis. Methods of accomplishing this notification include, but are not limited to, providing a handout, posting a notice in living areas, and/or including the information in the inmate orientation. Some jurisdictions prefer to issue the items at intake, as a matter of routine. Local jurisdictions should be aware that personal care items could be a sensitive issue and a subject of litigation. Sanitary napkins and tampons must be available so female inmates can continue to use whichever form of protection is more effective for them, pursuant to **Penal Code Section 4023.5 (a)(1)**.

As noted in the guideline to **Section 1206.5, Management of Communicable Diseases in a Custody Setting**, there is reason to believe sharing electric razors and razor blades may be a significant route of transmission for some contagious diseases such as AIDS and hepatitis. It is important that inmates not share these devices unless they are carefully disinfected between uses. Disposable razors cannot be effectively disinfected; therefore, they must be disposed of after an individual's use.

It is possible that in certain housing units where security is a special issue (e.g., maximum security housing or some administrative segregation units), to devise a method to allow repeated use of a disposable razor by the same individual. This may take the form of a board or cabinet with numbered slots that correspond to individual inmates or their respective cells. Considering the low cost of these plastic disposable razors, it may not be cost effective to bother collecting and reissuing them. Instead it may be less expensive to discard them after each use and reissue a fresh razor. In that vein, it is important to develop policy and procedures for the safe and secure discarding of disposable razors, as improper or unsafe practices may compromise facility safety and security.

The local environmental health department can provide information about current approved methods for sanitizing the equipment. A previous method of using a phenol-based dip or phenol containing soaking solutions (often a blue colored solution) is no longer acceptable.

1266. Showering.

There shall be written policies and procedures developed by the facility administrator for inmate showering/bathing. Inmates shall be permitted to shower/bathe upon assignment to a housing unit and at least every other day or more often if possible.

Guideline: Ideally, inmates should be able to shower or bathe daily. Virtually all modern podular jails have showers in the dayroom areas that allow staff to easily supervise inmates showering. However a facility is designed, inmates must be permitted to shower or bathe at least every other day. Inmates whose jobs or work assignments cause them to require more frequent showers should be permitted to shower whenever necessary.

Please see **Title 24, Sections 470A.2.1** relating to showers in reception/booking areas, and **470A.3.4**, for the design requirements for shower/bathing areas.

1267. Hair Care Services.

(a) Hair care services shall be available.

(a) Inmates, except those who may not shave for reasons of identification in court, shall be allowed to shave daily and receive hair care services at least once a month. The facility administrator may suspend this requirement in relation to inmates who are considered to be a danger to themselves or others.

(b) Equipment shall be disinfected, after each use, by a method approved by the State Board of Barbering and Cosmetology to meet the requirements of Title 16, Division 9, Sections 979 and 980, California Code of Regulations.

Guideline: How hair care services are provided is at the discretion of the facility manager. This regulation states that the services must be available. It purposely leaves open the options of inmates caring for their own and/or other inmates' hair, inmate barbers being assigned, and/or non-inmate personnel being used. There is no expectation that the facility must use barbers licensed by the State Board of Barbering and Cosmetology. This regulation includes application in Type I facilities that hold inmate workers long enough to need a haircut. The regulation does not require a sink in every area in which hair care occurs. Places can be designated for hair cutting where sinks or similar special apparatus are not available.

Section 1265, Issue of Personal Care Items, states equipment shared among inmates must be sterilized before each individual use, as transmission of HIV and hepatitis is germane for hair care equipment that is capable of drawing blood. The same regulations that apply to barbers in the community regarding the sanitizing and disinfecting of equipment apply to jails. Sterilizing chemicals, as any other cleaning and disinfecting agents, must be stored in secure areas inaccessible to inmates.

Local environmental health departments can provide information about current, approved methods for sanitizing the equipment addressed here. A former method of using a phenol-based dip or phenol containing soaking solutions (often a blue colored solution) is not acceptable.

ARTICLE 14. BEDDING AND LINENS

1270. Standard Bedding and Linen Issue.

The standard issue of clean suitable bedding and linens, for each inmate entering a living area who is expected to remain overnight, shall include, but not be limited to:

(a) one serviceable mattress which meets the requirements of Section 1272 of these regulations;

(b) one mattress cover or one sheet;

(c) one towel; and,

(d) one blanket or more depending upon climatic conditions.

Temporary holding facilities which hold persons longer than 12 hours shall meet the requirements of (a), (b) and (d) above.

Guideline: This regulation applies to all facilities, including Type I facilities which house inmates overnight and with regard to **(a), (b), and (d)**, temporary holding facilities which hold inmates for longer than 12 hours. Please see **Title 24, Section 470A.2.2** for the requirement that cells or rooms located in temporary holding facilities be equipped with a bunk if inmates are held longer than 12 hours.

The number of blankets a facility issues will vary with the geographical location, the season of the year and the presence or absence of climate control equipment in the facility. A second sheet may be issued in addition to the required mattress cover or sheet, at the discretion of the facility manager. Providing these items may help in maintaining inmate morale.

The intent of this regulation is to provide adequate bedding for most inmates; however, managers should identify those circumstances where issuing this bedding would be contraindicated by other regulations (e.g., **Section 1219, Suicide Prevention Plan)**. Numerous instances have been reported where inmates identified as suicide risks affected their own deaths by using torn bedding. Facility policies and procedures to implement the suicide prevention plan should address how bedding and linens are handled in this situation.

1271. Bedding and Linen Exchange.

There shall be written policies and procedures developed by the facility administrator for the scheduled exchange of laundered and/or sanitized bedding and linen issued to each inmate housed. Washable items such as sheets, mattress covers, and towels shall be exchanged for clean replacement at least once each week. If a top sheet is not issued, blankets shall be laundered or dry cleaned at least once a month or more often if necessary. If a top sheet is issued, blankets shall be laundered or dry cleaned at least every three months.

Guideline: The intent of this regulation is for each inmate being housed to receive clean, freshly laundered bedding and linen, and for that bedding and linen to be exchanged regularly. Providing clean bedding is a relatively easy way to avoid management problems. Facility managers are required to provide clean blankets and bedding; however, they should identify those circumstances where issuing bedding would be contraindicated by other standards (e.g., inmates on suicide watch; **Section 1219, Suicide Prevention Plan).**

Blankets used in health care areas or by inmates who are ill, pose a health risk and should be cleaned more frequently than those used in general housing. Since communicable diseases can be transmitted via bedding and blankets, facilities have an obligation to disinfect and clean the items for the protection of both inmates and facility staff. It is advisable to check with your local health authority or public health officer to determine the best ways to disinfect bedding.

1272. Mattresses.

Any mattress issued to an inmate in any facility shall be enclosed in an easily cleaned, non-absorbent ticking, and conform to the size of the bunk as referenced in Title 24, Section 2-470A.3.5, Beds. Any mattress purchased for issue to an inmate in a facility which is locked to prevent unimpeded access to the outdoors shall be certified by the

manufacturer as meeting all requirements of the State Fire Marshal and the Bureau of Home Furnishings' test standard for penal mattresses, Technical Information Bulletin Number 121 dated April 1980.

Guideline: Mattresses issued to inmates must be constructed with an easily cleaned, nonabsorbent ticking or cover. Such a covering allows potential stains and soil to be wiped off with a damp cloth, and does not require periodic sterilization as did the old fashioned cotton ticking.

Mattresses pose a significant fire and smoke hazard in locked detention facilities. For this reason, this regulation requires that mattresses used in any locked facility must meet the California Bureau of Home Furnishing's test standard for penal mattresses, **Technical Information Bulletin Number 121**. This test considers a number of important issues, such as, the ease or difficulty with which the mattress can be made to burn, the smoke it generates and the percentage of weight loss.

Supply catalogs often claim their mattresses meet specified federal, or other non-California standards, but unless it specifies meeting the California test standard, it is not approved for locked facilities in California. When purchasing mattresses, be certain they are safe by verifying that the contract includes certification, by the manufacturer, that the mattresses you receive have satisfactorily met the penal mattress test criteria established in the California Bureau of Home Furnishings **Technical Information Bulletin Number 121**, dated April 1980. Keep the letter of certification on file for review by the fire marshal during his/her annual inspection. To determine the fire safety of existing mattresses, ask the vendor to describe the contents of the mattress and consult with your local fire authority. The mattress is likely to be safe if it is borate treated cotton, neoprene, or polyurethane foam known as Hypol. Regular polyurethane, untreated cotton, fiber pad, and some foams are not acceptable in secure facilities.

ARTICLE 15. FACILITY SANITATION AND SAFETY

1280. Facility Sanitation, Safety, and Maintenance.

The facility administrator shall develop written policies and procedures for the maintenance of an acceptable level of cleanliness, repair and safety throughout the facility. Such a plan shall provide for a regular schedule of housekeeping tasks and inspections to identify and correct unsanitary or unsafe conditions or work practices which may be found.

Medical care housing as described in Title 24, Section 2-470A.2.14, shall be cleaned and sanitized according to policies and procedures established by the health authority.

Guideline: It is important to maintain a clean facility that is in good repair. The facility administrator determines “an acceptable level” of cleanliness, repair and safety for his or her facility, and is responsible for developing policy and procedure to maintain that level. The intent is not that each facility be spotlessly clean all the time but that the facility is maintained in a safe and healthful manner.

A plan for an acceptable level of cleanliness, repair and safety should include**:**

1. a statement of policy about the environmental health and safety of the facility;
2. designation of the responsibilities and duties necessary to implement the plan;
3. schedules of functions (e.g., daily, weekly, monthly or seasonal cleaning, maintenance, pest control and safety surveys);
4. lists of equipment, cleaning compounds, chemicals and related materials used in the facility and instructions on how to operate, dilute or apply the material in a safe manner; and,
5. records of self-inspection procedures, forms and actions taken to correct deficiencies.

Additionally, consideration should be given to general job descriptions, and/or limitations, relating to personnel assigned to carrying out the plan. Training for accident prevention and avoidance of hazards, relating to the maintenance of the facility, should be provided.

When inmate work crews are used, additional controls should be implemented to account for all equipment and cleaning materials. Specialized tasks such as changing air filters and cleaning ducts, or facility pest control are more appropriately handled by a maintenance department or by contract with private firms.

Pest control and eradication is crucial to keeping a facility clean and safe. **Section 1212, Vermin Control, Section 1264, Control of Vermin in Inmates' Personal Clothing** and **Appendix 11, Lice and Scabies Control** all address aspects of this issue. Additionally, your health authority, responsible physician, local public health personnel and State Department of Health Services personnel will be able to provide information and assistance in this regard.

Appendix

RESOURCE LIST BY CATEGORY

Alcohol, and other Drugs
Includes Methadone, and related treatment information and resources
Department of Alcohol and Drug Programs, 1700 K Street, Sacramento, CA 95814, Resource Center, (916) 327-3728, 1-800-879-2772, http://www.adp.cahwnet.gov

This search engine will help you find a specific alcohol and other drug treatment provider within California. The State of California Department of Alcohol and Drug Programs Data Management Services Section have prepared this Directory. http://txworks.adp.ca.gov/tww.asp

California Society of Addiction Medicine
74 New Montgomery, Suite 230, San Francisco, CA 94105, 415/927-5730 • FAX: 415/927-5731, http://www.csam-asam.org/

Drug Enforcement Administration
The federal website is http://www.usdoj.gov/dea/, includes list of schedule drugs, etc. Division Offices in California are San Diego Division, **(858) 616-4100,** San Francisco Division, **(415) 436-7900.**

Prescribing Pain Medications
Guidelines: see http://www.medbd.ca.gov/Controlled_Substances.htm

Ambulance and related Emergency Personnel
Paramedics, Emergency Medical Technicians 1 & 2
Emergency Medical Services Authority, 1930 9th Street, Suite 100, Sacramento, CA 95814, (916) 322-4336, Paramedic Licensure (916) 323-9875 http://www.emsa.cahwnet.gov/

Barbers and Cosmetologists
State Board of Barbering and Cosmetology, 400 R Street, Room 4080, Sacramento, CA 95814, 916/445-7061, 1-800-952-5210, http://www.barbercosmo.ca.gov/

Communicable Diseases
Includes both National and State resources for HIV, Hepatitis, Tuberculosis, etc.

The California Division of Communicable Disease Control is a branch of the California Department of Health Services, Prevention Services. Their website is http://www.dhs.ca.gov/ps/

The **National Center for Disease Control** (CDC) provides on-line information regarding various diseases, injury prevention, and updates on communicable diseases. You can assess information on-line at http://www.cdc.gov. If you do not find the information you need from their Health Topics page, or categories of Frequently Asked Questions, their phone number is 1-800-311-3435.

Dentists, and related professionals
Board of Dental Examiners, 1430 Howe Avenue, Suite 85B, Sacramento, CA 95825, 916/263-2292, http://www.dbc.ca.gov

Dental Hygienist & Dental Assistants (Dental X-ray), Committee on Dental Auxiliaries, 1430 Howe Avenue, Suite 58, Sacramento, CA 95825 (916) 263-2595 ,Fax (916)263-2709, http://www.comda.ca.gov

Environmental Health

Environmental Health Specialist, Registered (formerly Sanitarian) Department of Health Services, REHS Program, 1616 Capitol Avenue, Building 174-2nd Floor, Sacramento, CA 95899, Environmental Management Branch – Robin Hook, Chief, (916) 449-5667, rhook@dhs.ca.gov ,

Environmental & Occupational Disease Control is a division of the California Department of Health Services. Included in this Division are Environment Health Investigations, Environmental Health Laboratory's, Occupational Health, etc. There are offices located throughout the State of California. Their website is http://www.dhs.ca.gov/ps/deodc/

Hearing Aid Dispensers

Contact Hearing Aid Dispenser Examining Committee, Medical Board of California, 1430 Howe Avenue, Suite 12, Sacramento, CA 95825, 916/263-2288, http://www.dca.ca.gov/hearingaid

Hospital And Psychiatric Facilities

Hospitals, Department of Health Services, 744 P Street, Sacramento, CA 95815 (916) 552-8700 (or local DHS office), http://www.dhs.ca.gov/lnc

State Mental Health Hospitals, Department of Mental Health (Headquarters) 1600 9th Street, Rm. 151, Sacramento, CA 95814, Voice (800) 896-4042 or (916) 654-3890, Fax (916) 654-3198, http://www.dmh.cahwnet.gov/Statehospitals

Psychiatric Health Facilities (PHFs) were established in 1978 as a low cost, high quality alternative to acute hospitalization facilities for individuals with major mental disorders. The Department of Mental Health currently licenses sixteen PHFs. Additional information can be found at http://www.dmh.cahwnet.gov/PsychFac

Inhalation Therapists

Respiratory Care Board, of California, 444 N. 3rd St., Suite 270, Sacramento, CA 95814, Phone (916) 323-9983, Fax (916) 323-9999, http://www.rcb.ca.gov

Laboratory &Clinical Technologists

Department of Health Services, Laboratory Field Services, 1111 Broadway 19th Floor Oakland, CA 94607, (510) 873-6360, http://www.dhs.ca.gov/ps/ls

Mental Health Counselors

Board of Behavioral Sciences (BBS), License verification, scope of practice regulations, and consumer complaints regarding Marriage, Family Therapists, Licensed Clinical Social Workers, Educational Psychologist, and Associate Clinical Social Workers. The BBS is located at 400 R Street, Suite 3150, Sacramento, CA 95814, (916) 445 – 4933, http://www.bbs.ca.gov

Nursing Related

Board of Registered Nursing (BRN), License verification, scope of practice regulations, and consumer complaints regarding, Registered Nurses, Nurse Practitioners, Nurse Anesthetists,

Certified Nurse MidWives. The BRN is located at 400 R Street, Suite 4030, Sacramento, CA 95814, (916) 322-3350. License Verifications: 1-800-838-6828,or http://www.rn.ca.gov

Board of Vocational Nursing and Psychiatric Technicians (BVNPT), License verification, scope of practice regulations, and consumer complaints regarding Licensed Vocational Nurses (LVNs) or Psychiatric Technicians (PTs). The BVNPT is located at 2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833, (916) 263-7800 http://www.bvnpt.ca.gov

Medical Assistants is an unlicensed health professional that performs non-invasive routine technical support services under the supervision of a licensed physician and surgeon or podiatrist in a medical office or clinic setting. Certification information, scope of practice issues and consumer complaints regarding Medical Assistants are provided by the Medical Board of California, Affiliated Healing Arts, Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236, http://www.medbd.ca.gov/MA.htm

Licensed Midwife is an individual who has been issued a license by the Medical Board of California to practice midwifery. Licensed midwives differ from certified nurse midwives. Certification information, verification of certification, and consumer complaints regarding Licensed Midwifes are provided by the Medical Board of California, Affiliated Healing Arts, Medical Board of California, Attn: Midwifery Program, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236, (916) 263-2382.

Non-licensed Technician Certification, Certification information, verification of certification, and consumer complaints regarding Certified Nurse Assistants, Home Health Aides and Hemodialysis Technicians. The certification program is incorporated into the Department of Health Services, Licensing and Certification Program, 1615 Capitol Avenue, P.O. Box 997416, MS 3301, Sacramento, CA 95899-7416, http://www.dhs.ca.gov/lnc.

Radiology and X-ray Related
Certification information, verification of certification, and consumer complaints regarding radiology technicians Department of Health Services, Radiologic Health Branch, 1500 Capitol Avenue, 5th Floor, MS 7610, Sacramento, CA 95814-5006, http://www.dhs.ca.gov/rhb

Radiology Equipment Registration and Certification
Department of Health Services, Radiologic Health Branch, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414 , (916) 327-5106, http://www.dhs.ca.gov/rhb

Osteopaths
Certification information, verification of certification, and consumer complaints regarding Osteopaths, Contact Osteopathic Medical Board of California, 2720 Gateway Oaks Drive, Suite 350, Sacramento, CA 95833, 916-263-3100, http://www.dca.ca.gov/osteopathic

Pharmacist and Pharmacy
Licensing information regarding both pharmacies and pharmacists. Includes certification information, verification of certification, and consumer complaints regarding pharmacists. It also includes an excellent continuum of statutes and regulations governing the management of medications. http://www.pharmacy.ca.gov

Physicians, and Psychiatrists
Certification information, verification of certification, and consumer complaints, contact the Medical Board of California, 1426 Howe Avenue, #54, Sacramento, CA 95825, (916) 263-2382, http://www.medbd.ca.gov/MW.htm

Physician Assistants
Certification information, verification of certification, and consumer complaints, contact the Medical Board of California 1424 Howe Avenue, Suite 35, Sacramento, CA 95825 (916) 263-2670, extension 202, http://physicianassistant.ca.gov

Psychologists
Certification information, verification of certification, and consumer complaints, contact the Medical Board of California 1424 Howe Avenue, Suite 35, Sacramento, CA 95825, (916) 263-0712, http://www.psychboard.ca.gov

CONFIDENTIAL MEDICAL/MENTAL HEALTH INFORMATION TRANSFER SUMMARY

Policy/Procedure Guidelines
Minimum Standards for Local Detention Facilities - Title 15, Section 1206

This discussion is provided as a guide for local detention facilities as they develop and implement health care and custody policies and procedures for providing summary health care information on all inmates who are transferred to another jurisdiction. Local policies and procedures will be more specific in terms of time frames, responsible staff and expected activities, than is outlined in this guideline. The requirement to send summary medical information is based on Title 15,CCR. Minimum Standards for Local Detention Facilities, Section 1206(n).[12] The purpose of this regulation is to provide continuity of health care for inmates who are transferred to other jurisdictions, reduce costs for replicating diagnostic tests and increase the safety of other inmates and staff.

Policy

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Upon notification of a pending inmate transfer, the standard Confidential Medical/Mental Health Information Transfer Summary, transport officer instructions and transmittal envelope will be completed by designated health care personnel and sent with the transporting officer.

Notification Procedures

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When advised that a transfer to another jurisdiction is pending, custody staff must notify health care personnel, with sufficient time for health care staff to prepare the Confidential Medical/Mental Health Information Transfer Summary. The notification to health care should include the following information:

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Name of inmate and any known aliases
Date of Birth
Estimated date and time of transfer
Receiving facility/jurisdiction

When there is insufficient advance notice to prepare the transfer summary, policy and procedures should identify how follow-up information will be forwarded to the receiving facility. (Custody staff should provide facilities in other jurisdictions with as much advance notice as possible when requesting that an inmate be made available for transport.)

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Confidential Medical/Mental Health Information Transfer Summary Form

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Health care staff will complete the transfer summary. The attached example format includes the following information:

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Indicate the date the summary was completed and if the inmate needs immediate health care attention upon arrival at the destination facility. Check the designated box if the inmate has not received health care services prior to being transferred. This designation is one means of advising the receiving facility that no health care information is available on the inmate.

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Provide the inmate's name and any known aliases.

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[12] Facilities that are accredited by the Institute for Medical Quality (IMQ)/California Medical Association (CMA), should also reference IMQ/CMA Standards for Health Services in Adult Detention Facilities, Section 503.

Provide the inmate's identification number at the sending facility and date of birth. This information may needed if follow-up information is requested.

Report any known allergies.

Identify any medical and mental health problems (including suicide attempts or concerns, dental needs, special medical diets, etc.).

List all currently prescribed medications, including those for tuberculosis. Provide the name of the medication, dosage and frequency, with both the start and stop dates. When possible, the inmate should be medicated with essential medications prior to transfer. Provision must be made for any essential medications that will be needed during transport.

Identify any prescribed treatments that are necessary for the inmate.

Indicate if the inmate is pregnant and provide the estimated date of delivery.

Report any lab test results and include pending appointments or lab work.

Provide the reading of the PPD test in millimeters of induration, and the date, together with the date and results of any chest x-rays. If the inmate has "suspect" or "active" TB disease, HSC Sections 121361 and 121362 (1993/94 "Gotch" legislation; formerly HSC Sections 3281 and 3282) require a treatment plan and advance notice to the local health officer in the sending jurisdiction and to the chief medical officer/responsible physician in the receiving facility prior to transferring the inmate. Indicate on the transfer summary, the date the local health officer was notified of the pending transfer. Forward a copy of the TB treatment plan to the health officer and attach the original to the transfer summary for the receiving facility. (Jails must coordinate policies with their local health officers when implementing this statute. Local health officers have policies and procedures established for implementation. They can also contact the State Department of Health Services, TB Control Branch with any questions.)

Identify the dates and results of tests for sexually transmitted diseases, as well as other tests that may have been conducted. Indicate if treatment was started.

Provide any additional information that may be relevant to understanding the inmate's health care needs. This includes recent exposures to communicable diseases. Photocopies of pertinent parts of the medical record may be enclosed; however, signed consent is required when these documents are provided .

The health care staff completing the summary form must sign it.

Delivery to Custody Staff/Transport Officer Instructions

Prior to delivering the information to custody staff so that they can provide it to the transport officers at the time of transfer, health care staff must seal the confidential information in a properly labeled envelope. All pertinent identification and transport information must be completed on the outside of the envelope. It should be clearly identified as medical information and addressed to the health care staff in the receiving facility. (An example format for the transfer envelope is enclosed.)

Tape or write the instructions for the transport officer to the outside of the confidential envelope. (Transport officers do not have access to the summary information inside the envelope.) Conditions transport officers should be informed of include: diabetes, communicable disease, mental health problems, pregnancy, suicidal tendencies, incontinence or vomiting, seizures, asthma, cardiac problems or medications, open wounds, medications required during transport, limitations to inmate movement, crutches, fractures, back, injuries, etc. Any information needed to protect the inmate during transport and special precautions needed for protection of the officer (in addition to universal precautions), should be disclosed.

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Custody staff who are responsible for releasing the inmate to the transport officers must provide them with the confidential medical envelope. Transport officers should request the information if it is not immediately forthcoming. (Some facilities have internal policies that inmates are not released from the facility without the summary health care information.)

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The sealed confidential health information envelope should accompany the inmate throughout transport, including in any layover facility en route to the destination institution.

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If the summary forms are faxed rather than delivered by the transport officer, custody staff should be advised accordingly and provision must be made to assure that transport officers have the health care information they need to safely manage the inmate during transport.

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Upon arrival at the destination facility, the confidential medical envelope must be delivered to reception/receiving personnel for delivery to designated health care staff. Facilities need internal procedures to transmit this information within their institution.

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Example Forms Provided

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Confidential Medical/Mental Health Information Transfer Summary: original to receiving facility; copy to inmate medical record

Confidential Medical/Mental Health Information Transfer Summary envelope

Correctional Facility Tuberculosis Patient Plan for inmates with suspect or known active TB disease: Please refer to the California Tuberculosis Controllers Association's (CTCA) website for current forms and information (www.ctca.org/publications/guidelines). At that site, reference "Correctional Facility Tuberculosis Patient Plan" for the current instructions and "Patient Plan Form."

(Printed on Transfer Envelope)

CONFIDENTIAL MEDICAL/MENTAL HEALTH INFORMATION TRANSFER SUMMARY
DELIVER TO: MEDICAL/MENTAL HEALTH SERVICES PERSONNEL

SENDING FACILITY: DESTINATION FACILITY:

INMATE NAME _____ DOB _____

AKA _____

SPECIAL TRANSPORT INSTRUCTIONS (TAPE OR WRITE HERE)

UNIVERSAL BODY SUBSTANCE PRECAUTIONS ARE TO BE TAKEN IN TRANSPORTING ALL INMATES

[✓] UNIVERSAL BODY SUBSTANCE PRECAUTIONS MEAN:

1. GLOVES SHOULD BE WORN FOR TOUCHING BLOOD AND BODY FLUIDS AND SHOULD BE CHANGED AFTER EACH CONTACT.
2. HANDS AND SKIN SURFACES SHOULD BE WASHED WITH SOAP AND WATER IMMEDIATELY IF CONTAMINATED WITH BLOOD OR OTHER BODY FLUIDS. HANDS SHOULD BE WASHED IMMEDIATELY OR AS SOON AS POSSIBLE AFTER GLOVES ARE REMOVED.
3. WORKERS SHOULD TAKE PRECAUTIONS TO PREVENT INJURIES CAUSED BY NEEDLES AND OTHER SHARP INSTRUMENTS. POCKET MASKS SHOULD BE USED WHEN PERFORMING CPR.
4. WORKERS WITH OPEN SORES OR DERMATITIS SHOULD REFRAIN FROM DIRECT INMATE CONTACT. CUTS SHOULD BE COVERED WITH ADHESIVE BANDAGES THAT REPEL LIQUIDS.
5. PREGNANT WORKERS SHOULD BE ESPECIALLY FAMILIAR WITH, AND STRICTLY ADHERE TO, PRECAUTIONS.

[ ] RESPIRATORY PRECAUTIONS MEAN (✓ if applicable):

ALTHOUGH IT IS UNLIKELY THAT AN INMATE WOULD BE TRANSPORTED WHILE ON RESPIRATORY PRECAUTIONS, IF THIS OCCURS, THE INMATE MUST WEAR A MASK AT ALL TIMES. THE MASK SHOULD BE CHANGED WHEN WET. ALL OTHER PERSONS IN THE TRANSPORT VEHICLE SHOULD BE PROVIDED WITH APPROVED RESPIRATORS AND INSTRUCTIONS.

Appendix 2

CONFIDENTIAL MEDICAL/MENTAL HEALTH INFORMATION TRANSFER SUMMARY

(Facility identification information: address, phone, fax, etc.)

[ ] NEEDS IMMEDIATE ATTENTION Date Summary Completed

[ ] No medical treatment given prior to transfer

INMATE NAME: INMATE ID #:

AKA: _____ DOB: _____

ALLERGIES: _____

Medical/Mental Health Problems (*including suicide attempts, dental needs, special diets, etc.*):

_____

Medications: DOSE ROUTE FREQUENCY START DATE STOP DATE
(including TB)

_____

_____

_____

Treatments:

_____

_____

Pregnant (Circle one):

Yes No Unknown

EDC: _____

TB: PPD Test: mm Date:

Chest X-Ray: [ ] normal [ ] abnormal Date:

Active TB Disease: [ ] suspect [ ] known

If suspect or known active TB disease, attach TB Patient Plan and provide the date Local Health Officer was notified of the pending transfer:

Other Lab Data:

Pending Appointments/Labs:

Attachments [ ] Yes [ ] No

Tests (Circle as appropriate): Treated Date

RPR/VDRL: Reactive Non reactive Yes No_____

GC: Negative Positive Yes No_____

Other screening test results and dates *(including hepatitis)*:_____

_____

Immunizations given/date :_____

Additional Information:

COMPLETED BY: _____ Signature/Title

SPECIAL TRANSPORT INSTRUCTIONS:

_____ (7/96)

MEDICAL TRANSFER SUMMARY
Facility Audit and Evaluation Procedures

Title 15, Section 1206 requires jails to provide medical transfer summaries when inmates are transferred to another jurisdiction. CDC policy establishes the same requirements for state prisons. Audit and evaluation procedures were developed by the "Interfacility Transfer of Medical Information Task Group," consisting of representatives from local jails, California Department of Corrections (CDC), Local Health Officers (LHO), Department of Health Services (DHS) and the California Youth Authority (CYA).

PURPOSE:

These audit and evaluation procedures provide facility custody and health care managers with a method to systematically assess their facilities for compliance with these requirements. Procedures require coordinated communication among all involved, as custody, transportation, booking and health care are all critical to assuring that this summary information accompanies inmates being transferred to other jurisdictions.

The following principles were adopted by the Task Group to establish that the audit and evaluation should:

1. Provide for internal evaluation within each facility, with each state or local facility auditing their own system;

2. Include a multidisciplinary evaluation of the process that involves custody, booking, transportation and health care staff;

3. Facilitate problem-solving and communication, both internal communication within a facility and external communication with other facilities;

4. Increase and support a level of awareness concerning the importance of having health care information on transferred inmates;

5. Be incorporated into the health authority's annual report to the jail administrator on health care problems and resolutions (required by Title 15, Section 1202, Medical/Mental Health Service Audits, for jails);

6. Be available to document compliance with transfer summary requirements for inspectors during county health inspections, BOC biennial inspections and CDC program evaluations; and,

7. Establish audit tools that are "flexible" enough to be customized by individual facilities to address known problems and be implemented in systems of varying size and complexity.

PROCEDURES:

- The attached evaluation and audit components have separate forms for evaluating booking/transportation procedures to send the information on "outgoing" inmates and receive the information on "incoming" inmates. In addition, there is an audit format to assess the quality of summary information provided by health services. These audits do not necessarily need to be completed during the same timeframe or on the same inmates.

- The Task Group encourages ongoing auditing and evaluating of policies and procedures and recommends that the audit and evaluation occur at least quarterly. However, each facility will need to determine the appropriate length of time for custody's transportation/booking data collection and the number of files to be included in the health services audit. Facility sizes vary dramatically. The time frames and number of files selected will depend upon resources, frequency of the audit, and both number and seriousness of the problems identified. One day for the booking/transportation component may be sufficient for most facilities. Ten files for the health services component may be reasonable for many facilities, but could constitute all transfers in some counties and a minuscule number in others.

- Coordination between custody and health services is essential. In many systems, there is already a "coordinating" team to address mutual concerns. This evaluation and audit may be folded into their responsibilities. Multiple staff will be involved, and each facility will need to establish roles and responsibilities.

CUSTODY - BOOKING/TRANSPORTATION EVALUATION

- Designed for designated booking or transportation staff to track "incoming" and "outgoing" inmates to identify the number having summary information.

- Scheduling the data collection should assess different shifts, as well as weekends and weekdays. All these factors would not necessarily need to be done at the same time, but could be staggered over a period of days, weeks, or perhaps even months.

- Data collection instructions are summarized on each of two forms (separate forms for incoming and outgoing inmates).

HEALTH SERVICES AUDIT

- Internal mo nitoring for quality and accuracy of the information must be done by health care staff at the facility sending the information. This is because they have the health care file. The also have access to transportation to lists verify that the information was an accurate reflection of the medical file and that summaries were completed on applicable inmates who were released.

- Designed for health services staff to use when reviewing selected health records to compare the information on the Transfer Summary and TB Patient Plan, with information in the file (e.g., medical and mental health).

- Data collection instructions are summarized on the Quarterly Medical Transfer Audit form. In addition, the following clarifications may be useful:

♦ Team Members: Multiple health care staff may be involved in this review (as a "team"), with individual members auditing a selected number of health records on "their" summary sheet. Identify the team members involved in the audit, if applicable.

♦ Health Care Staff Completing this Page: This audit of medical records can be completed by anyone legally authorized to access medical records. For example, this could include medical records staff, designated and authorized support staff with appropriate training; nurses, health services managers, etc. Custody staff would not review the medical record to conduct this audit, but as part of the coordinating team, they would have access to the audit summary.

♦ Reviewed by: Some larger health care systems may have a review level. For smaller systems this may not be applicable.

♦ Coding Key: Enter 0, 1 or 2 in each column for each health record that is audited. If an audited record is out-of-compliance, it is recommended the reason be noted in the "comments" section. Compliance can be totaled on each page.

Coordination and Communication:

- The Task Group carefully considerable what should happen with the data once it is available in a facility. The overall goal is to support a network of communication: Internally, among custody, transportation and health care staff within a facility; between individual facilities, on a facility-by-facility basis, to resolve problems; and, with inspectors during annual health inspections, BOC biennial inspections, and CDC program evaluations. Health officer, BOC and CDC inspections assess issues on a broad, systemic basis; however, the practical, immediate impact will come from commitment and communication within and among facilities.

- Designate a central coordinator or coordinating team. Develop a plan for consolidating the information and discussion among custody, transport and health care managers. Consolidate and maintain the results for review by health, BOC and CDC inspectors.

- Title 15, Section 1202 (Medical/Mental Health Service Audits) requires the jail health authority to provide a written report to the facility administrator, at least annually, about health services issues. That report is to include recommendations/plans for resolving the problems and the results of this evaluation and audit should be considered in that report.

- Develop a corrective action plan for each area that is "systemically" out-of-compliance. Corrective action will differ if non-compliance is related to a broad policy-procedure problem or a training issue for an individual staff person or shift.

- Develop a system of communicating concerns about the information received (or not received) from another facility. The enclosed letter is one method of documenting concerns, but, in many instances it may be appropriate to also have less formal procedures for advising another facility of concerns.

INCOMING INMATES: Booking/Transportation Transfer of Medical Information Evaluation

Facility: _____ **Shift:** _____

Date[1]	Inmate Name[2]	Booking/ Inmate #[3]	Sending Facility[4]	Summary Received[5]	Transport Instructions[6]	Staff Initials[7]	Comments[8]
				Yes No	Yes No		
				Yes No Yes No	Yes No Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No Yes No	Yes No Yes No		
				Yes No	Yes No		

[13]Date the inmate is admitted to the facility.
[2] Inmate's last, first name.
[3]Use the booking/inmate number from the sending facility.
[4]Record the originating facility that sent the inmate to you.
[5]Circle "yes" or "no" to indicate if a transfer summary was received with "incoming" inmates.
[6]Circle "yes" or "no" to indicate if the incoming health care information included transport instructions. (Transport instructions are not always required.)
[7]Initials of the staff person completing the information for each individual inmate.
[8]Insert any additional or explanatory information that may be useful in interpreting the evaluation.

Provide the completed Booking/Transportation Evaluation to health services to evaluate if transport instructions were required, if health care staff have a completed summary on file, or if a summary was received by some other means (e.g., fax). Health care staff will note findings in "comments."

[1] Note: An effective immunization is available and should be offered to staff and inmates who are particularly susceptible to infection. Advice from a medical consultant should be sought to determine when vaccination is indicated.

Appendix 4

OUTGOING INMATES: Booking/Transportation Transfer of Medical Information Evaluation

Facility: _____ **Shift:** _____

Date[1]	Inmate Name[2]	Booking/ Inmate #[3]	Destination Facility[4]	Summary Sent[5]	Transport Instructions[6]	Staff Initials[7]	Comments[8]
				Yes No	Yes No		
				Yes No Yes No	Yes No Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No	Yes No		
				Yes No Yes No	Yes No Yes No		
				Yes No	Yes No		
				Yes No	Yes No		

[1] Date the inmate was released from the facility for transport elsewhere.
[2] Inmate's last, first name.
[3] Use the booking/inmate number from your facility.
[4] Record the ultimate "destination facility" to which you are sending the inmate.
[5] Circle "yes" or "no" to indicate if a health care transfer summary was included in the transport information sent with the inmate at the time of release to transport staff.
[6] Circle "yes" or "no" to indicate if the health care summary information included transport instructions. (Transport instructions are not always required.)
[7] Initials of the staff person recording the information for each individual inmate.
[8] Insert any additional or explanatory information that may be useful in interpreting the evaluation.

Provide the completed Booking/Transportation Evaluation to health services to evaluate if transport instructions were required, if health care staff have a completed summary on file, or if a summary was received by some other means (e.g., fax). Health care staff will note findings in "comments."

Appendix 4

County Jail or State Facility
Address
City, State Zip

Date

Letter should be directed to the desired point of contact: e.g., Health Care Manager, Sheriff, Chief, Warden, Etc.
County Jail or State Facility
Address
City, State Zip

RE: TRANSFER OF HEALTH INFORMATION

Dear _____:

The transfer of health information focuses on improving the quantity and quality of health information transferred among facilities. Staff at our facility has recently discovered that inmate(s) received from your facility did not have a transfer summary or had deficiencies in regard to the health information that was provided. These deficiencies are summarized in the attached document for your review and follow-up.

Please feel free to give me a call if any of my staff or I can be of further assistance. I can be reached at (xxx) xxx-xxxx. We appreciate your commitment to this process and your prompt response.

Sincerely,

Signature block

Enclosure

For Jails:
cc: Local health Officer
Field Representative, Board of Corrections (600 Bercut Dr., Sacramento, CA 95814)

For CDC facilities:
cc: Health Care Regional Administrator, CDC (P.O. Box 942883, Sacramento, CA 95283)

Preface:

The following plan is specific to **Section 1206.5, Management of Communicable Diseases in a Custody Setting**. It is intended to set the framework for discussions between the facility manager, responsible physician, and the county health officer. The health authority and responsible physician should also refer to the DHS Division of Communicable Disease Control for specific recommendations in the management of reportable conditions, not addressed by this regulation www.dhs.ca.gov/ps/dcdc

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COMMUNICABLE DISEASE MANAGEMENT PLAN OUTLINE

Developed jointly by responsible Physician, Facility Administrator, and County Health Officer.

I. *IDENTIFICATION*

- Which diseases should be included (based on local incidences – range from vermin to HIV)
- Section 1051, Communicable Diseases (including tuberculosis, hepatitis, sexually transmitted disease (STD), AIDS, or others); requires separation from general population pending medical evaluation and subsequent isolation as needed
- Section 1207, Medical Receiving Screening
  - Known communicable diseases
  - Symptoms of communicable disease
  - Role of check x-rays at intake (large jails)
- Screening work furlough inmates

II. *TREATMENT*

- Responsibility of medical staff
- Considerations include:
  - Develop treatment plan for suspect or verified cases
  - Length of incarceration of persons with latent disease
  - Direct observed therapy
  - Need for isolation; procedures for initiating and discontinuing isolation

III. *CONTROL*

- Reporting within facility (HSC 121070)
  - How it is done/forms used
  - Confidentiality

- Reportable diseases, procedures/forms (medical staff must report certain diseases to local health officer)
- Universal Precautions

- Other Special Precautions (e.g., Enteric)

- Protective Measures/Control Equipment
  - Negative pressure isolation rooms; address appropriate design, monitoring and maintenance of room to specifications
  - HEPA filters and ultra violet lamps
  - Personal protective equipment such as gloves and respirators
  - Medical waste containers (sharps, red bags), disposal
  - Special equipment for sputum induction

- Contact Tracing
  - Procedures for consulting with local health officer, initiating, testing, reporting results and preventative therapy

- Separation of immunologically vulnerable (HIV, pregnant)
  - Housing in areas of lower inmate turnover to separate from inmates who may have incubating diseases which have not been diagnosed (e.g., Rubella, Chicken pox, TB, etc.)

- Prophylaxis during disease outbreaks

- Transportation issues
  - Procedures for separation/protection

IV. FOLLOW-UP

- Link with local Health Department

- Transfer procedures
  - Notify receiving facility's medical officer and Local Health Officer prior to transferring inmate with known or suspected active TB
  - Notify Local Health Officer prior to release of these inmates to community

V. TRAINING

- Inmate training

- Staff training
  - Institution procedures for communicable disease management; OSHA regulations

VI. COMMUNICABLE DISEASE PRECAUTIONS FOR INMATES

- Inmate workers
  - Kitchen
  - Laundry
- Exposures in housing areas

VII. EMPLOYEE ISSUES

- Screening (e.g., TB skin tests, baseline and periodic)

- Prevention (e.g., Hepatitis B vaccine, INH for latent TB)

- Plan of action for disease exposure incidents
  - Report to supervisor
  - Document (e.g., facility incident reports, workers' compensation reports, DHS 8479, DHS 8459, Cal/OSHA log 200)
  - Timely referral to treating physician
  - Testing for HIV, Hepatitis B, C, etc.

- Pregnant and Immunocompromised Employees – Work Assignments

VIII. STATISTICS

- Tracking patterns of diseases (e.g., conversion rates of tuberculin skin test results among employees, incidence and prevalence rates for communicable diseases among inmates)

Appendix 5

COMMUNICABLE DISEASES OF CONCERN

IN THE DETENTION SETTING

DISEASE	FEATURES FAVORING OCCURRENCE IN DETENTION FACILITIES	FACTORS PROMOTING SPREAD IN DETENTION FACILITIES	CONSEQUENCES OF INFECTION
BACTERIAL MENINGITIS [1]	Young adults are at risk for infection. Normal populations carry the bacteria capable of producing disease.	Respiratory transmission facilitated by crowding in confined spaces. Can be spread by sharing cups, cigarettes, etc.	Disease can produce outbreaks requiring public health intervention. Rapid diagnosis and treatment necessary to prevent mortality.
CHLAMYDIA	Risk factors include multiple sexual partners. Younger women (e.g., under age 25) most frequently affected.	Not thought to be commonly transmitted in the jail setting, but possible in the case of illicit sexual activity.	Pelvic inflammatory disease, infertility in women. Relative absence of symptoms, particularly in women, may allow infection to go undetected for prolonged periods of time.
GONORRHEA	Risk factors include multiple sexual partners.	Not thought to be commonly transmitted in the jail setting, but possible in the case of illicit sexual activity.	Pelvic inflammatory disease, tubo-ovarian abscess and infertility in females. Urethritis in males. Disseminated infection, arthritis, proctitis, pharyngitis and conjunctivitis may occur in either sex.
HEPATITIS A [1]	Occurs commonly under conditions of poor sanitation. Approximately 30-day incubation period allows apparently healthy persons to enter a facility and infect others before exhibiting symptoms. Infection is spread by fecal-oral route.	Sewage contamination, such as flooding of cells, promotes spread. Poor hygienic practices of infected food service workers can produce outbreaks. Laundry workers may be infected via improper handling of contaminated laundry. Cellmates with close personal contact with a case may be at risk for contracting the infection.	Infection may produce illness ranging from mild (even asymptomatic) to moderately severe or prolonged, but most persons recover uneventfully. "Institutional hysteria" and public relations when a case becomes known are significant factors.
HEPATITIS B [2] ("HBV")	High rate of risk behaviors for infection exhibited by inmates (e.g., IV drug use, multiple sex partners).	Injection drug use, shared tattoo devices and toothbrushes, contact with saliva, injury on contaminated needles or other sharps. Can be transmitted via human bites.	A percentage of infected persons develop chronic infection, remain infectious, and may develop chronic and ultimately fatal liver disease. Can be transmitted from pregnant woman to unborn child, and among close household contacts. Initial infection may occur without symptoms.

[2] Note: An effective immunization is available and should be offered to all staff persons who may be at risk for exposure.

DISEASE	FEATURES FAVORING OCCURRENCE IN DETENTION FACILITIES	FACTORS PROMOTING SPREAD IN DETENTION FACILITIES	CONSEQUENCES OF INFECTION
HEPATITIS C ("HCV")	Risk behaviors for infection common to inmates include IV drug use, recipients of blood transfusions.	Injection drug use, shared tattoo devices, injury on contaminated needles or other sharps, possible transmission via sexual contact.	There is a significant percentage of infected persons who will develop a chronic infection; which may produce chronic and ultimately fatal liver disease. Initial infection may occur without symptoms.
HIV	High rate of risk behaviors for infection exhibited by inmates (e.g., IV drug use, multiple sex partners).	Injection drug use, shared tattoo devices, sexual activity.	Chronic and ultimately fatal disease; can be transmitted from pregnant woman to unborn child. Initial infection may occur without symptoms.
INFLUENZA [3]	Annual outbreaks possible during late Fall and Winter months. All persons considered susceptible, but elderly, chronically ill, and immunocompromised at greatest risk for serious disease.	Respiratory transmission facilitated by crowding in confined spaces.	Can be complicated by bacterial pneumonia, sometimes resulting in death.
RUBELLA [4] ("GERMAN MEASLES")	Occurs in immigrants and others who may have been inadequately immunized; adults immunized as children may be susceptible due to waning immunity.	Respiratory transmission facilitated by crowding in confined spaces.	Serious consequences to a developing fetus can occur if disease is contracted during early pregnancy.
RUBEOLA [4] ("MEASLES")	Occurs in immigrants and others who may have been inadequately immunized as children; adults immunized as children may be susceptible due to waning immunity.	Respiratory transmission facilitated by crowding in confined spaces.	Can produce serious illness, including encephalitis and is especially dangerous during pregnancy.
SYPHILIS	Risk factors include multiple sexual partners, particularly where there is an exchange of sex for drugs.	Not thought to occur commonly in the jail setting, but possible in the case of illicit sexual activity.	Untreated disease can produce a wide range of complications involving cardiovascular and neurologic systems. Babies born to infected mothers may suffer congenital abnormalities and/or fatal infection. HIV more readily transmitted to persons with genital ulcers associated with primary syphilis. Cure may be difficult in persons co-infected with HIV.

[3] Note: An effective immunization is available and should be offered to staff and inmates who are particularly susceptible to infection. Advice from a medical consultant should be sought to determine when vaccination is indicated.
[4] Note: An effective immunization is available and should be offered to staff and inmates who are particularly susceptible to infection. Advice from a medical consultant should be sought to determine when vaccination is indicated.

Appendix 5

DISEASE	FEATURES FAVORING OCCURRENCE IN DETENTION FACILITIES	FACTORS PROMOTING SPREAD IN DETENTION FACILITIES	CONSEQUENCES OF INFECTION
TUBERCULOSIS ("TB")	Persons who are at increased risk of TB include: those with HIV infection; substance abusers (especially injection drugs and alcoholics); homeless; immigrants from countries with high rates of TB; persons with a history of incarceration; and medically undeserved populations	Transmission from persons with active disease. Shared airspace, including recirculating air, allows spread. Crowded conditions promote spread.	Latent TB infection can be treated to prevent development of TB disease and TB disease can be treated. Persons co-infected with HIV and TB can develop TB disease rapidly. Drug resistant TB may be refractory to treatment.
VARICELLA [5] ("CHICKENPOX")	Some adults vulnerable due to lack of natural infection during childhood.	Respiratory transmission facilitated by crowding in confined spaces.	Can produce severe illness in adults including orchitis, encephalitis, and pancreatitis. Can cause severe fetal damage or death if infection occurs during pregnancy. Severe infection can occur in immuno-suppressed. Can be complicated by later occurrence of Herpes Zoster ("shingles").

[5] An effective immunization is available and should be offered to staff and inmates who are particularly susceptible to infection. Advice from a medical consultant should be sought to determine when vaccination is indicated.

Communicable Disease Notification
to Facility Manager

!!! CONFIDENTIAL !!!

For use by facility manager only

Inmate Name _____
Communicable disease _____
Date of diagnosis _____

Recommended precautions:

Blood/secretion (includes wound) [ ]

Enteric (fecal) [ ]

Respiratory [ ]

Housing recommendations:

Single cell [ ]

Negative Pressure Isolation Room [ ]

General housing [ ]

Anticipated period of communicability:

Indefinite [ ]

Other (specify)_____

Completed by_____
(Name/Title) Date

DISCLOSURE OF THE COMMUNICABLE DISEASE DIAGNOSIS ON THIS PAGE IS INAPPROPRIATE, ILLEGAL, AND SUBJECT TO PROSECUTION AS A MISDEMEANOR (HSC 121070), WITH THE EXCEPTION OF FACILITY MANAGER COMMUNICATING TO AFFECTED EMPLOYEES OF THE FACILITY.

MEDICAL RECEIVING – SCREENING

Appendix 7

DATE AND TIME BOOKED		NAME		X REF NO.
RACE	SEX	SOCIAL SECURITY NO.	D.O. B.	NEXT OF KIN
CHARGES				NEXT OF KIN'S PHONE NO.

OFFICER'S OBSERVATIONS

Does the prisoner appear to be:

❑ YES ❑ NO (1) Mentally retarded or exhibiting hearing or speech problems?
❑ YES ❑ NO (2) Suffering limited movement? (WHY) _____
❑ YES ❑ NO (3) Under the influence of alcohol or drugs?
❑ YES ❑ NO (4) Infested with lice or crabs?
❑ YES ❑ NO (5) A danger to self or others?
❑ YES ❑ NO (6) Disoriented, confused, impaired level of consciousness?

(1) Check all that apply:

❑ Sweaty	❑ Shaking	❑ Alcohol on Breath
❑ Calm	❑ Deep Yellow Skin or Eyes	❑ Bleeding (specify)_____
❑ Sleepy	❑ Agitated	❑ Deformities (specify)_____
❑ Cuts, Bruises, Needle marks (specify)_____		❑ Persistent Cough
❑ Other: _____		

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ARRESTEE'S HEALTH HISTORY

❑ YES ❑ NO (1) Have you ever tried to harm yourself?
❑ YES ❑ NO (2) Are you thinking of harming yourself now?
❑ YES ❑ NO (3) Do you hear voices?
❑ YES ❑ NO (4) Do you have problems with mood swings or depression?
❑ YES ❑ NO (5) Are you currently receiving psychiatric treatment?
❑ YES ❑ NO (6) Have you been a patient in a mental hospital within the past 5 years?
❑ YES ❑ NO (7) Have you ever been treated at a regional center or diagnosed with developmental problems?
❑ YES ❑ NO (8) Have you ever been treated for tuberculosis?
❑ YES ❑ NO (9) Have you had a cough for more than three weeks with any of the following: fever, weight loss, fatigue, night sweats?
❑ YES ❑ NO (10) Have you recently been in contact with someone who has tuberculosis?

(1) Do your currently have any of the following conditions? (INDICATE YES WITH AN X)

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( ) High blood pressure	( ) Seizures	( ) Tuberculosis	( ) Skin Condition
( ) Heart problems	( ) Asthma	( ) Psychiatric	( ) Gonorrhea
( ) Diabetes	( ) Hepatitis	( ) Syphilis	( ) Herpes
( ) Dental problems	( ) Allergies	( ) Deformities	( ) AIDS

❑ YES ❑ NO (12) Do you have any other medical problems/injuries? (specify) _____
❑ YES ❑ NO (13) Do you take any medications? (type/dose)_____
❑ YES ❑ NO (14) Are you allergic to any medications? (type)_____
❑ YES ❑ NO (15) Are you wearing contacts, prosthesis, casts, using crutches?
❑ YES ❑ NO (16) Have you had a recent head injury/traffic accident/fight?
❑ YES ❑ NO (17) Do you have any drug/alcohol use that could cause withdrawal problems?

a. Type/amount used daily?_____
b. Time of last dose or drink? _____

❑YES ❑NO (18) Medical treatment prior to incarceration? Medi-Cal or Insurance?_____

FEMALE ONLY

❑ YES ❑ NO (1) Are you taking birth control pills? Type/Dose_____
❑ YES ❑ NO (2) Are you pregnant? Due Date _____
❑ YES ❑ NO (3) Have you recently: -delivered? Date: _____ -miscarried? Date: _____

DISPOSITION

❑ YES ❑ NO Fit for incarceration
❑ YES ❑ NO Refer for Medical Evaluation
❑ YES ❑ NO Refer for Mental Health Evaluation
❑ YES ❑ NO Other (describe) _____

COMMENTS:_____

_____

NO ACUTELY ILL PERSON IS TO BE ACCEPTED INTO THE FACILTY

OFFICER/NURSE'S SIGNATURE _____ BADGE NO. _____

ARRESTEE'S SIGNATURE _____ _____

SCREENING QUESTIONNAIRE AND INFORMATION FOR FOOD SERVICE WORKERS

Questionnaire

Have you recently or are you currently experiencing any of the following:

	Yes	No	If yes, when
Open sores on your skin	_____	_____	_____
Runny nose/sore throat/cough	_____	_____	_____
Vomiting/diarrhea	_____	_____	_____
Loss of appetite	_____	_____	_____
Change in color of urine	_____	_____	_____
Change in color or texture of bowel movements	_____	_____	_____
Fever	_____	_____	_____
History or recent exposure to hepaitis/tuberculosis	_____	_____	_____

Rules

In order to function as a food services worker, you must comply with the following rules:

1. You must wash your hands immediately upon reporting for work in the kitchen and after using the restroom.

2. You will wear disposable plastic gloves whenever handling food directly for serving.

3. You must have completed this health questionnaire.

4. If you develop any of the above symptoms, you must report them immediately to the supervising staff.

5. You must wear a protective hair net or hat at all times while in the kitchen. Combing your hair while working is prohibited. Shoes (not sandals) are required.

6. You may not smoke at any time.

If you break one of these rules, you will immediately be taken off kitchen duty.

By signing this form I acknowledge that I understand and agree to abide by the above rules and regulations, and that the information I have provided is true.

_____

Signature / Printed Name Date

Cleared for food service work [ ] yes [ ] no

Signature/Title/Date_____

Sources of Vitamin A

Vitamin A Vegetables	Serving Size	Micrograms RE	IU
Broccoli, Frozen, Chopped Boiled	1/2 cup	174	1741
Broccoli, Raw, Chopped	1/2 cup	68	678
Cabbage, Raw, Shredded	1/2 cup	105	47
Cabbage, Boiled, Shredded	1/2 cup	6	99
Cabbage, Chinese, Boiled, Shredded	1/2 cup	58	2183
Carrots, Raw	1 med.	2025	20253
Carrots, Boiled, Sliced	1/2 cup	1915	19152
Carrots, Canned, Sliced	1/2 cup	1006	10055
Carrots, Frozen, Boiled, Sliced	1/2 cup	1292	12922
Chard, Swiss, Boiled, Chopped	1/2 cup	276	2762
Greens, Beet, Boiled	1/2 cup	367	3672
Greens, Collards, Frozen, Boiled	1/2 cup	508	5084
Greens, Collards, Boiled, Chopped	1/2 cup	175	3491
Greens, Kale, Boiled, Chopped	1/2 cup	481	4810
Greens, Kale, Frozen, Boiled	1/2 cup	413	4130
Greens, Mustard, Frozen, Boiled	1/2 cup	335	3353
Greens, Mustard, Boiled, Chopped	1/2 cup	212	2122
Greens, Turnip, Raw	1/2 cup	213	2128
Greens, Turnip, Boiled, Chopped	1/2 cup	396	3959
Greens, Turnip, Canned	1/2 cup	420	4196
Greens, Turnip, Frozen, Boiled	1/2 cup	654	6540
Lettuce, Romaine, Shredded	1/2 cup	73	728
Mixed Vegetables, Canned	1/2 cup	995	9551
Mixed Vegetables, Frozen	1/2 cup	389	3892
Peas and Carrots, Canned	1/2 cup	739	7386
Peas and Carrots, Frozen	1/2 cup	621	6209
Peppers, Jalapeno, Canned, Chopped	1/2 cup	116	1156
Potato, Sweet, Baked with Skin	4 oz.	2487	24877
Potato, Sweet, Boiled w/o skin, Mashed	1/2 cup	2796	27969
Potato, Sweet, Candied	1 piece (2-1/2X2”dia.)	440	4398
Potato, Sweet, Canned, Mashed	1/2 cup	1929	38571
Potato, Sweet, Canned, Syrup Packed	1/2 cup	702	7014
Pumpkin, Boiled, Mashed	1/2 cup	132	1320
Pumpkin, Canned	1/2 cup	2691	17500
Pumpkin Pie Mix, Canned	1/2 cup	1121	11202
Spinach, Raw, Chopped	1/2 cup	188	1880
Spinach, Canned	1/2 cup	939	9390

Sources of Vitamin A

Vitamin A Vegetables	Serving Size	Micrograms RE	IU
Spinach, Frozen, Boiled	1/2 cup	739	7395
Squash, Butternut, Baked	1/2 cup	714	7141
Squash, Butternut, Boiled, Mashed	1/2 cup	473	4007
Squash, Hubbard, Baked, Cubed	1/2 cup	616	6156
Tomato, Boiled	1/2 cup	89	892
Vitamin A Fruits	**Serving Size**	**Micrograms RE**	**IU**
Apricot Nectar	1/2 cup	165	1651
Apricots, Raw	3 med.	277	2769
Apricots, Canned, Heavy Syrup	4 halves	111	1107
Apricots, Canned, Juice Pack	3 halves	142	1420
Apricots, Canned, Light Syrup	3 halves	112	1124
Cantaloupe, Raw, Pieces	1/2 cup	258	2579
Mango, Raw	1 med.	805	8061
Papaya, Raw	1 med.	85	863
Persimmon, Japanese, Raw	1 med.	365	3641
Prunes, Dried	3 med.	167	1669
Tangerine, Raw	3 oz.	77	773
Vegetable Juice Cocktail	1/2 cup	142	1000
Vitamin A Misc. Food Items	**Serving Size**	**Micrograms RE**	**IU**
Braunschweiger Sausage	18 grams	760	2529
Cheese, American	1 oz.	82	343
Cheese, Cream	1 oz.	124	405
Eggs, Boiled	1 large	84	280
Margarine	1 tsp.	47	141
Milk, Fluid, 1%, 2%, or skim	8 oz.	140-149	420-447
Liver, Beef, Braised	3 oz.	9087	35679
Pudding, from reg. mix w/lowfat milk	1/2 cup	70	200

Source: Pennington, Jean, A.T. Bowes and Church Food Values of Portions Commonly Used. 17th ed. New York, Lippincott- Raven Publishers, 1998.

Appendix 9

Sources of Vitamin C

Vitamin C Vegetables	Serving Size	Mg Vit. C
Beans, Lima, Baby, Frozen, Boiled, Immature	1/2 cup	5
Beans, Lima, Fordhooks, Frozen, Boiled	1/2 cup	11
Beans, Lima, Canned, Drained	1/2 cup	0
Beans, Refried, Canned	1/2 cup	7.5
Bean Sprouts, Fresh	1/2 cup	10
Broccoli, Raw, chopped	1/2 cup	41
Broccoli, Boiled	1/2 cup	58
Brussel Sprouts, Boiled (4 Sprouts)	1/2 cup	48
Brussel Sprouts, Frozen, Boiled	1/2 cup	36
Cabbage, Chinese, Boiled, Shredded	1/2 cup	22
Cabbage, Chinese, Raw, Shredded	1/2 cup	16
Cabbage, Green, Raw, Shredded	1/2 cup	11
Cabbage, Green, Boiled, Shredded	1/2 cup	18
Cabbage, Red, Raw, Shredded	1/2 cup	20
Cabbage, Red, Boiled, Shredded	1/2 cup	26
Cabbage, Savoy, Raw, shredded	1/2 cup	11
Cabbage, Savoy, Boiled, Shredded	1/2 cup	12
Cauliflower, Raw, Pieces	1/2 cup	23
Cauliflower, Boiled, Pieces	1/2 cup	27
Cauliflower, Frozen, Boiled	1/2 cup	28
Chard, Swiss, Boiled, Chopped	1/2 cup	16
Corn, Canned, Vacuum Pack	1/2 cup	9
Beet Greens, Boiled	1/2 cup	18
Greens, Chicory, Raw, Chopped	1/2 cup	22
Greens, Collards, Frozen, Boiled	1/2 cup	22
Greens, Kale, Frozen, Boiled, Chopped	1/2 cup	16
Greens, Kale, Boiled, Chopped	1/2 cup	27
Greens, Mustard, Boiled, Chopped	1/2 cup	18
Greens, Mustard, Frozen, Boiled	1/2 cup	10
Greens, Turnip, Frozen, Boiled	1/2 cup	18
Greens, Turnip, canned	1/2 cup	18
Greens, Turnip, Canned	1/2 cup	14
Jicama	3 oz.	14
Kohlrabi, Raw	1/2 cup	5
Kohlrabi, Cooked	1/2 cup	44
Lettuce, Loose-leaf	1/2 cup	5
Lettuce, Romaine	1/2 cup	7
Okra, Boiled	1/2 cup	10
Onions, Boiled	1/2 cup	6

Vitamin C Vegetables	Serving Size	Mg Vit. C
Parsnips, Boiled	1/2 cup	10
Peas and Carrots, Canned	1/2 cup	8
Peas and Carrots, Frozen	1/2 cup	6
Peas, Canned or Frozen, Boiled	1/2 cup	8
Peppers, Chili, Hot, Canned, Chopped	1/2 cup	46
Peppers, Sweet, Boiled	1/2 cup	51
Peppers, Sweet, Raw, Chopped	1/2 cup	45
Peppers, Sweet, Canned	1/2 cup	33
Peppers, Sweet, Freeze Dried	1/4 cup	30
Pimientos	1 Tbsp.	10
Potatoes (Vit. C content declines w/storage)		
Potatoes, Baked, Flesh & Peel in oven	1 potato	26
Potatoes, Baked, Flesh only	1 potato	20
Potatoes Boiled Cooked in Peel	2-1/2" diameter	17.6
Potatoes, Boiled cooked w/o skin	1 potato	10
Potatoes, Canned, w/o skin	1/2 cup	5
Potatoes, French Fries	10 pieces	5
Potatoes, Mashed from Flakes	1/2 cup	10
Potatoes, Mashed from Granules	1/2 cup	3
Potatoes, Sweet, Baked w/skin	4.1 oz.	28
Potatoes, sweet, Boiled w/o skin	1/2 cup	28
Potatoes, Sweet, Canned, Mashed	1/2 cup	6
Pumpkin, Canned	1/2 cup	5
Rutabaga, Boiled, Cubed	1/2 cup	16
Sauerkraut, Canned	1/2 cup	17
Spinach, Raw	1/2 cup	8
Spinach, Boiled	1/2 cup	9
Spinach, Canned	1/2 cup	15
Spinach, Frozen, Boiled	1/2 cup	12
Squash, Summer, Scallop, Boiled	1/2 cup	11
Squash. Acorn, Boiled, Mashed	1/2 cup	8
Squash, Hubbard, Baked, Cubed	1/2 cup	10
Squash, Hubbard, Boiled, Mashed	1/2 cup	8
Squash, Summer, Scallop, Boiled	1/2 cup	10
Squash, Summer, Zucchini, Raw	1/2 cup	6
Succotash, Boiled	1/2 cup	8
Tomato, Raw	2-1/2" diameter	23
Tomato, Stewed, Canned	1/2 cup	15
Catsup	2 Tbsp.	4

Source: Pennington, Jean, A.T. Bowes and Church Food Values of Portions Commonly Used. 17th ed. New York, Lippincott-Raven Publishers, 1998.

Appendix 9

Menu Worksheet (Adult Facilities)

DAY	**(MENU WORKSHEET (ADULT FACILITIES)**				
CYCLE					
SEASON					
	BREAKFAST	**LUNCH**	**DINNER**	**SNACK**	**TOTAL**
PROTEIN GROUP (3) 6 OUNCES OR MORE /					
* Lean Meat & Poultry / TVP					
* Legumes (3x/sk)					
MILK GROUP (2) 16 ounces / day					
* 8 oz Milk - 250 mg Ca					
* Reduced Fat					
* 400 IU Vit. D / qt * 200 RE Vit. A / qt					
FRUITS & VEGETABLES (5)					
5 SERVINGS					
* Daily Fresh Fruit or * 30 mg Vit. C / serving					
* 200 RE Vit. A / serving					
GRAIN GROUP (6)					
6 SERVINGS * 3 Servings Whole Grains					
FAT					
1 Tbsp Fat or Oil / day					
ADDED SERVINGS Milk					
Fruits & Vegetables					
Grains					
Other					

Lice and Scabies Control

Lice and scabies are infestations that can provide significant management problems within the custody environment. In many situations, inflated fears of acquiring the conditions are as much a problem as an infestation itself. There are many misconceptions about lice and scabies, which contribute to a tendency of both staff and inmates to overreact to possible infestations. At the same time, it is important to understand what measures are necessary to adequately treat identified cases and how to prevent spread to others. While infestations are usually more of a nuisance than medically serious, persons who also have HIV infection can be severely affected by scabies. In addition, a facility that does not promptly and effectively contain and treat infestations will likely be subjected to severe criticism for maintaining "unsanitary" conditions. Efforts to adequately control infestations may be hampered by the development of resistance to available treatments, as well as the improper application of otherwise effective agents. Local health departments can serve as resources to facility staff in guiding treatment according to the most current recommendations.

It should be noted that treatment options include both prescription and non-prescription medications. Facility procedures should assure that properly licensed medical staff is involved in the use of prescription items. Further, procedures should also take into account precautions that apply to any of the available treatments, such as their use on pregnant women or persons with allergic reactions to the medication (even those which are applied topically to the skin). It is also critically important to remember that sprays designed for use on clothing and other surfaces are not to be used on people, and that this practice can result in serious adverse reactions. The practice of treating all new intakes into a facility for lice based upon a vague suspicion of the possibility is outmoded. Instead, treatment should be based upon more definite findings. When in doubt, it is recommended that the individual be separated from other inmates until a medical examination can establish or rule out a diagnosis more definitely.

Despite the fact that all forms of infestation tend to cause itching and scratching, scabies and the various forms of lice are each unique in their characteristics. They should be recognized and treated as distinctly different forms of infestation. Common myth has suggested that one form of louse can turn into another, and this is simply not true. The three commonly recognized types of lice infestations of humans have highly specific preference for their location on the human body. Furthermore, while lice are tiny but visible blood-sucking insects, an entirely different type of organism causes scabies - a mite that cannot be readily seen without a microscope. The following is a summary of the common types of infestations that affect humans.

Appendix 11

HEAD LOUSE		
Description	**Transmission**	**Treatment**
3-mm long insect that is found on the scalp hair and produces nits (egg cases), which adhere to the hair shaft.	Transmitted by direct contact or on shared objects (e.g., combs, towels, headphones, etc.).	Permethrin 1% creme rinse (Nix™) is the treatment of choice. It should be applied for 10 minutes, and then rinsed off. Alternatives include and several over-the-counter pyrethrins (e.g., RID™). Removal of nits (manually or using a fine-toothed comb) is optional. Treatment, if properly applied will usually render the nits non-viable. Wash clothes, bed linens, and towels in hot water and dry on hot cycle for at least 20 minutes. Soak combs, brushes, hair bands, etc. in water at least 130 degrees F. for at least 10 minutes. Items that come into contact with the head that cannot be washed (e.g., headphones) should be sealed in a plastic bag for at least 2 weeks.

BODY LOUSE		
Description	**Transmission**	**Treatment**
Slightly larger in size than the head louse. Not found on the body itself, but clings to fibers in the seams of clothing.	Transmitted through direct body contact or sharing of contaminated clothing or bedding. Crowded living conditions, poor hygiene, and infrequent laundering enhance transmission.	Improved hygiene. Wash and dry clothing and bed linens on hot cycles. Pediculocides not essential, but may be used in epidemic situations.

PUBIC LOUSE		
ption	**Transmission**	*nent*
1 mm long, shaped like a crab. Adheres to pubic hair and may also affect hair on the trunk, beard, eyelashes, and axillary (armpit) areas. Produce nits that are visible on hair shafts.	High rate of transmission, but only through intimate contact.	Permethrin 1% creme rinse (Nix™) is the treatment of choice. It should be applied for 10 minutes, and then rinsed off. Pediculocides should not be applied to eyelashes. Alternative treatments for this area may include application of petrolatum five times a day or gentle removal with baby shampoo. Resistant cases should be referred to an ophthalmologist. Clothing and bed linens should be washed and dried on hot cycles for at least 20 minutes.

SCABIES

Description	Transmission	Treatment
0.3 mm - 0.4 mm eight-legged mite, which burrows into human skin. Although it eventually produces a generalized itchy rash, it particularly affects the web spaces of the fingers, flexor aspects of the wrists, waistline, and skin fold areas including the genitalia, axillae (armpits), umbilicus, and upper thighs. Some infested persons may have no symptoms. Persons with HIV infection may have a severe form of infestation with thick crusting of the skin.	Direct contact. The mite may survive 24-36 hours at room conditions, but is unlike to spread via inanimate objects.	Permethrin 5% cream (Elimite™) applied to all skin surfaces (per package instructions) for 8-12 hours. A second treatment in 1 week is recommended. Should not be used in pregnant or nursing women. Less effective alternatives include lindane 1% lotion for 8 hours, precipitated sulfur 6% in petrolatum for three consecutive nights (treatment of choice in pregnant or nursing women), and crotamiton (Eurax™). Oral treatment with a single dose of ivermectin has been described in the literature, but has not been approved by the Food and Drug Administration for this indication. Clothing and bed linens should be washed and dried on hot cycles for at least 20 minutes on the morning after each treatment. Alternatively, they may be sealed in plastic bags for at least one week.

Deciding whether cellmates of persons with lice or scabies should also receive treatment depends on their degree of contact (keeping in mind the mode of transmission), coupled with an assessment of anxiety levels of those at risk. It is important to remember that close contact with persons with scabies may be infested, but may not always develop symptoms. Although the routine practice of treating entire housing units on a precautionary basis is excessive, if there are no contraindications, one should not be overly restrictive about treating persons whose degree of contact is uncertain.